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IN THE

Supreme Court Of The United States

October Term, 1997

EASTERN ENTERPRISES,
Petitioner,
v.
KENNETH S. APFEL, COMM'R OF SOCIAL SECURITY, *et. al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

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VOLUME II, PAGES 231a TO 344a

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COAL COMMISSION REPORT

A Report to the Secretary of Labor and the American People

The Secretary of Labor's Advisory Commission on United Mine Workers of America Retiree Health Benefits

November 1990
Washington, D.C.

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Jan Horbaly
Executive Director

November 5, 1990

Honorable Elizabeth Dole
Secretary of Labor
Washington, D.C. 20210

Dear Madam Secretary:

The Coal Commission was created on March 12, 1990 "to focus on health care issues arising from the 1950 and 1974 UMWA Benefit Plans and the effects of resolving these issues on the coal industry as a whole." The Commission also was directed to advise you on:

1. The financial status and prospects of the United Mine Workers of America 1950 and 1974 Pension Trusts (Pension Plans) and 1950 and 1974 Benefit Trusts (Benefit Plans);
2. The provision and means of delivery of health care benefits to coal industry retirees and their dependents who either currently are or formerly were represented by the UMWA; and
3. Arrangements to assure long-term financial viability of the 1950 and 1974 Pension and Benefit Plans.

The Commission is pleased to forward to you its findings and recommendations on the financial status of the 1950 and 1974

UMWA Health and Retirement Funds and on the quality and availability of health care benefits for UMWA retirees.

In general, the Commission reached consensus on a wide range of issues aimed at ensuring the long-term financial stability of the Funds. These issues include imposition of a statutory obligation to contribute on current and past signatories to the National Bituminous Coal Wage Agreement, mechanisms to prevent future dumping of retiree health care liabilities, statutory authority to utilize excess pension assets, and the implementation of state-of-the-art managed care techniques. Of course, a number of factual, legal, financial and policy matters will have to be reviewed as these matters are resolved.

The principal substantive difference among members was on the question of who should provide financing for orphan retirees. Many Commission members believe that orphans represent an industry-wide problem that should be resolved on an industry-wide basis. Others believe that only current and past signatories should be required to finance orphan health care. Implicit in both views is that collective bargaining alone cannot resolve the problem of delivering promised benefits to retirees.

As Chairman, I commend you for the extraordinary people you selected to serve on the Commission. I could not ask for a better group of more highly qualified and truly dedicated public servants to work on the issues referred to the Commission. Each member, serving without remuneration, contributed enormous amounts of time and energy to the issues considered. Together, with an exceptionally strong staff, the members worked tirelessly to solve an extremely difficult and perplexing problem.

Many constructive and creative ideas were presented and discussed, and some forceful arguments were offered in support of varying solutions. This report represents the very best consensus that could be achieved considering the strong views held by different Commission members on the numerous issues addressed.

On behalf of the Commission, I wish to thank those at the Department of Labor and

the many others who helped the Commission accomplish its work. The Commission appreciates too your sincere interest and generous support in helping to solve this very difficult and complex health care problem confronting the coal industry.

Respectfully yours,

/s/ W.J. Usery, Jr.
Chairman

Enclosure

Advisory Commission on
Mine Workers Retiree Health Benefits

EXECUTIVE SUMMARY

The UMWA Health and Retirement Funds (Funds) is a unique institution. It was created in the White House in a contract between the federal government and the UMWA and for 45 years, it has provided comprehensive health care benefits for retired miners and their families. Unfortunately, the combination of skyrocketing health care costs, an increasing number of retirees who have been abandoned by their employers, and a smaller percentage of coal producers making contributions to the UMWA Funds have put the health care program for retirees in a financial crisis.

In the last 10 years, the health care costs paid by the UMWA Health and Retirement Funds have doubled from $117.4 million to $245.3 million. By 1993, the Funds will have an estimated deficit of $300 million. Much of the cost is attributable to "orphaned" retirees whose companies have gone out of business or ceased paying for health care benefits. More than half of the Funds' population is composed of orphan retirees. How to continue to provide health benefits to "orphans" is the essence of the problem. Signatory coal operators who are still in the coal business are willing to pay the fair cost of their retirees, but are increasingly unwilling to shoulder the burden of paying for orphans, which they view as an industry-wide problem. Health care benefits are an emotional subject in the coal industry, not only because coal miners have been promised and guaranteed health care benefits for life, but also because coal miners in their labor contracts have traded lower pensions over the years for better health care benefits.

The current deficit for the Funds is $114.7 million, and the deficit will continue to grow at the current rate of contribution. A close analysis of the administration and operation of the Funds reveals that they are doing an adequate job in administering the Funds and in providing health care benefits for the retired coal miners. In short, the growing deficit is much broader than the administration of the Funds.

There is consensus, that is, agreement among most of the Commission members, on a number of important issues. The Commission firmly believes that the retired miners are entitled to the health care benefits that were promised and guaranteed them and that such commitments must be honored. The Commission agrees that a statutory obligation to contribute to the plans should be imposed on current and former signatories to the National Bituminous Coal Wage Agreement. The Commission agrees that mechanisms must be enacted to prevent future dumping of retiree health care obligations on the Funds. The Commission supports statutory authority for the parties to utilize excess pension assets to reduce existing deficits. Finally, the Commission supports the implementation of managed care and cost containment activities designed to reduce costs without the loss of benefits.

The principal substantive point on which the Commission did not reach consensus is whether the entire industry should contribute to the resolution of the problem of orphan retirees. Many commissioners support the enactment of a small health care fee on current and former signatories, and other coal producers to help pay for health benefits of retirees who have no company to provide such benefits. Others believe that only current and former signatories should be required to contribute. As a result, two alternative approaches for a possible long-term solution are offered by the Commission. It is recognized there may be appropriate modifications to either of these solutions, and that other satisfactory plans could be developed.

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INTRODUCTION

A. Creation of the Commission. On March 12, 1990, Secretary of Labor Elizabeth Dole appointed an 11-member Commission to review and make recommendations concerning the financial crisis confronting the 1950 and 1974 UMWA (United Mine Workers of America) Benefit Funds. Secretary Dole appointed W.J. Usery, Jr. to serve as Chairman of the Advisory Commission on United Mine Workers of America (UMWA) Retiree Health Benefits (the Commission) and directed the Commission to present its findings and recommendations to her by October 11, 1990. On September 27, 1990, Secretary Dole extended the Commission's reporting date to October 17, 1990, to permit the public additional time to make presentations and submit materials to the Commission for consideration. On October 18, 1990, Secretary Dole extended the Commission's reporting date to October 31, 1990 to allow the Commission members time to submit written proposals and statements for inclusion in the final report. On November 1, 1990, Secretary Dole extended the Commission's reporting date to November 5, 1990 to allow additional time for preparation and submission of the Commission's final report.

B. Statement of the Problem. The medical care program for retired coal miners represents a unique history of cooperation and confrontation between the private sector and the government. The UMWA Health and Retirement Funds were created in an agreement between the federal government and the United Mine Workers of America during a period of government seizure of the mines. It was shaped by a federally-appointed commission charged with examining health care in America's coal fields. Over the years, it has been recognized by specific legislative treatment, reshaped by numerous court decisions and kept alive in times of peril by government intervention in the collective bargaining process.

Retired coal miners have legitimate expectations of health care benefits for life; that was the promise they received during their working lives and that is how they

planned their retirement years. That commitment should be honored. But today those expectations and commitments are in jeopardy.

The Commission was asked to examine the problem and to recommend a solution for assuring that orphan retirees in the 1950 and 1974 Benefit Trusts will continue to receive promised medical care. To deal effectively with its charge, the Commission had to consider the unique nature of the Funds; the sharp decline in the contribution base supporting them; the rapidly escalating medical care costs; and the strong historical tie among the Funds, its beneficiaries and the collective bargaining relationship which has been in place for over 40 years. In short, the Commission was asked to reconcile the changing landscape of the coal industry with the legitimate demands of history.

The 1950 and 1974 Benefit Funds are in financial crisis for several reasons. First, the number of coal companies making contributions to the Funds has declined significantly. In 1950 the companies making contributions to the Funds accounted for 80 percent of the coal produced in the nation; by 1990 companies making contributions to the Funds account for only 30 percent of national coal production. Second, the cost of providing health care to retired miners and their families has increased significantly from 1950 to 1990. In the last 10 years alone, the total cost of health care benefits paid by the Funds has doubled from $117.4 million to $245.3 million. Third, there has been a steady increase in the number of orphaned retirees whose employers have either gone out of business or no longer provide health care benefits. The combination of these factors has left the Funds, which were created to provide retired coal miners and their families with one of the finest health care programs in the nation, in financial crisis.

While the 1950 and 1974 UMWA Benefit Funds are inadequately funded, the 1950 UMWA Pension Fund is over funded by approximately $237 million, assuming the current plan actuaries assumptions are realized. This surplus of pension funds has prompted legislative proposals (1) to

transfer some of these excess assets to the Benefit Funds and (2) to require certain coal operators--who were, but who are now no longer contractually obligated to make contributions--to resume making contributions to the Benefit Funds.

The crisis created by the high cost of health care is not unique to the coal industry. It is a major problem in the United States and one that affects much of American industry. The need to provide quality health care for American workers is a national challenge and, according to Secretary Dole, this challenge affects the "entire work force and [America's] competitive edge in the world market." The high cost of health care is the main issue in 87 percent of the labor disputes and is an issue that will dominate the collective bargaining process in the years to come.

On January 1, 1990, the parties to the strike at the Pittston Coal Company reached a settlement in their 10-month-long labor dispute, and on February 19, 1990, a new four-and-a-half-year contract was ratified by members of the UMWA. The payment of health care benefits to retired and disabled miners and their families was a major issue in the strike and was responsible in large measure for the subsequent formation of this Commission.

The current deficit for the 1950 and 1974 UMWA Health Benefit Funds is $114.7 million. By 1993, the deficit for the 1950 and 1974 UMWA Health Benefit Funds is expected to be more than $300 million. Secretary Dole contends that in order "to avoid a [more] serious crisis [in the future]," a "long-term resolution is needed" to deal with the problem of accelerating health care costs in the coal industry. That crisis could come as early as 1993 when collective bargaining commences between the UMWA and members of the Bituminous Coal Operators' Association (BCOA) on a successor agreement to the expiring 1988 National Bituminous Coal Wage Agreement (NBCWA).

The federal courts also have been active in resolving disputes concerning the operation and contributions to the Funds. In addition, Congress has enacted legislation affecting the coal industry, most recently, the Clean Air Act, and has

considered legislation authorizing the transfer of money from the 1950 Pension Fund to the 1950 Benefit Fund.

The escalating cost of providing adequate health care to coal miners and their families, particularly the increasing population of orphan retirees, cannot properly or fairly be solved by the parties through collective bargaining alone. The Secretary of Labor's creation of this Commission is evidence in itself that the issue facing the Funds is not one that lends itself to resolution through negotiation and mediation. The problem of the escalating cost of health care is a problem of potentially great magnitude which today is threatening to bankrupt the UMWA Health and Retirement Funds, and which tomorrow may threaten the financial solvency of union and nonunion coal mining companies alike. In short, at the present rate of inflation in health care costs, many companies over the longer term may not be able to provide health care coverage for their employees because the cost of health care may exceed the company's profits.

The time to deal with the problem is now before it becomes even more serious. If the coal industry and government can work together to solve this problem as it has worked together to solve problems in the past, the whole nation can benefit from the results. Not only will the coal industry remain healthy, but the nation too can benefit from the results achieved from the cooperative effort of the industry and the government.

C. Charge of the Commission. For these reasons, Secretary Dole created the Coal Commission and directed it "to focus on health care issues arising from the 1950 and 1974 UMWA Benefit Plans and the effects of resolving these issues on the coal industry as a whole." In particular, she asked the Commission to advise her on:

1) The financial status and prospects of the United Mine Workers of America 1950 and 1974 Pension Trusts (Pension Plans) and 1950 and 1974 Benefit Trusts (Benefit Plans);

2) The provision and means of delivery of health care benefits to coal industry retirees and their dependents who either currently are or formerly were represented by the UMWA; and

3) Arrangements to assure long-term financial viability of the 1950 and 1974 Pension and Benefit Plans.

The members appointed by Secretary Dole to serve on the Coal Commission have a wide range of experience and represent all facets of the coal industry. The union, coal operators--both BCOA and non-BCOA, the private insurance industry, as well as academics, actuarial, medical and government policy experts, and those with extensive experience in labor law, mediation, and labor negotiations make up the membership. According to Deputy Secretary of Labor Roderick A. DeArment, who opened its first meeting, the Commission will have "free reign to explore any and all solutions" to the financial crisis confronting the 1950 and 1974 Benefit Funds.

D. Work of the Commission. In achieving the objectives set forth by the Secretary of Labor, the Commission reviewed the history of the trust funds and the types of health care benefits beneficiaries are entitled to receive. The members also reviewed the financial status of the health care and pension trust funds, and examined projected costs and expenditures for a 20-year period. In addition, the Commission analyzed how the health care trust funds are managed. Based on the information considered and examined, the Commission reached the findings and conclusions set forth in the report and submit their recommendations for ensuring the integrity of retiree health benefits in the coal industry.

CHAPTER ONE

THE COAL INDUSTRY

A. The Industry. In the United States the domestic coal industry continues to grow in both size and strategic importance as the nation's most abundant and economic basic energy resource. In 1990 domestic coal production should reach 1 billion tons, marking the fourth consecutive year of growth. Valued at an estimated $21 billion today, domestic coal production ranks as one of the nation's most important basic industries.

B. Background. Coal had its origin millions of years ago in the lush forests and dense swamps that once covered vast areas of the earth's surface. Over the intervening ages, this vegetative matter was subjected to different sets of temperatures and pressures and became a solid hydrocarbon rather than a gaseous or a liquid one.

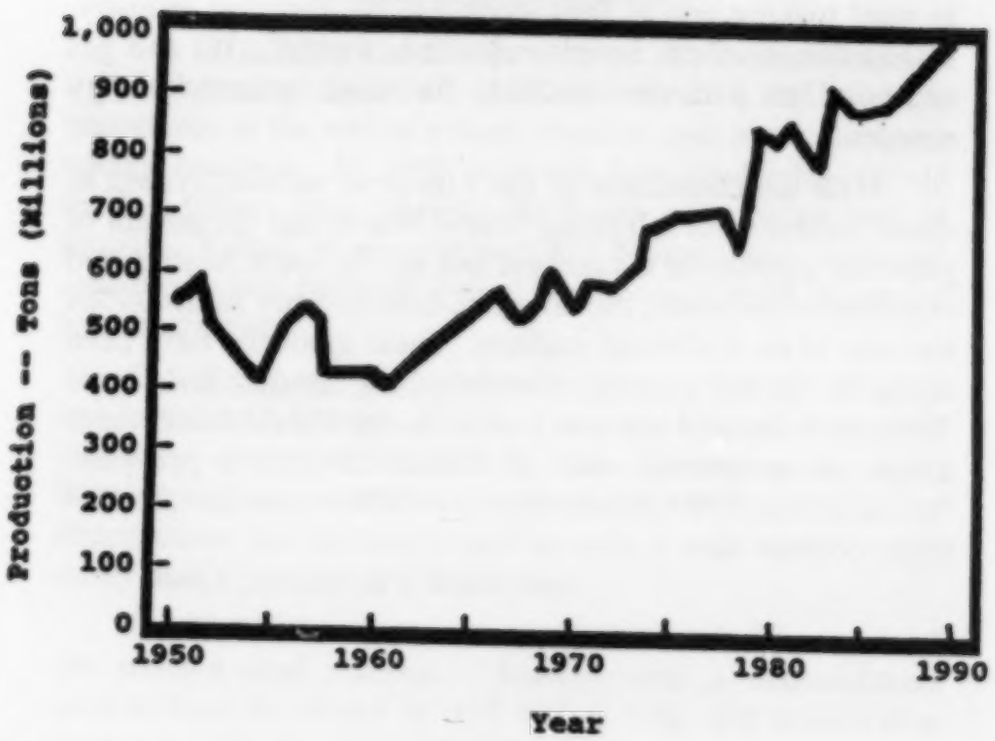
The United States possesses approximately 35 percent of the world's coal reserves. Indeed, with a demonstrated reserve base in excess of 470 billion tons and recoverable reserves of nearly 270 billion tons, U.S. coal reserves exceed the entire world's supply of oil and gas and are adequate to meet today's demand levels for centuries to come.

Geologically, the oldest and highest quality coals are found in numerous seams throughout much of Appalachia. Midwestern and Rocky Mountain coal deposits are generally younger and of somewhat lower quality while the youngest and lowest quality coals are the vast lignite deposits of the northern Great Plains and the Gulf Coast states. Coal quality is generally measured by heat content and residual impurities and it can vary considerably from region to region, from seam to seam and even within a given seam. Of particular interest today is sulfur content which can range from very low to medium or high depending upon the prevailing geologic conditions when the coal was formed.

C. Coal Utilization and Production. As with other primary energy sources, coal is used principally for the heat

that is released upon combustion which can transform water into high temperature, high pressure steam to perform useful work. Certain coals also contain chemical properties needed in steel making and as feed stock for the chemical industry. In addition, coal can be converted into synthetic oil and gas and used as a direct substitute for these primary energy sources.

With the conversion of the American railroad system to diesel locomotives following World War II and the advent of plentiful supplies of natural gas and oil for space heating and commercial purposes, the domestic coal industry in the 1950s lost two of its traditional markets. These gradually have been replaced by the growing electric utility market and, since 1960, coal demand and production in the United States have grown at an average rate of almost 5 percent per year. Production in 1990 should exceed 1 billion tons for the first time. (Figure 1)



(FIGURE 1)

Today, about 86% of the coal produced in the United States is used to generate electricity and accounts for nearly 56% of the nation's total electric power production. In addition, approximately 10% of industry output is exported to the European Common Market, South America, and Pacific Rim countries and contributes significantly to our international trade balances. The remaining production is consumed by heavy industry for processing and steel making purposes.

Coal is produced in 26 States with 60 percent mined east of the Mississippi River. The five largest coal producing States, accounting for nearly two-thirds of the nation's output, are Wyoming, Kentucky, West Virginia, Pennsylvania and Illinois. Other major producers are Texas, Virginia, Montana, Indiana, and Ohio.

Nearly two-thirds of the nation's output comes from surface mines which use large mobile excavating equipment to remove the overburden and expose coal seams located within a few hundred feet of the surface. Upon completion of mining, the surface is then restored to its approximate original contour and to pre-mined levels of vegetative productivity. Underground mining is also highly mechanized with yesterday's picks and shovels replaced by continuous mining machinery that safely and economically recovers coal seams to depths of 2,000 feet or more. Very often, the coal is further processed after mining to remove impurities and upgrade quality before shipment to customers by conveyor belt, truck, rail, barge or ocean vessel.

Thus, as a plentiful, economic and secure energy resource, coal is and should remain a cornerstone of our national energy supply for generations to come.

D. Industry Structure. The coal industry is one of extremes, both very large and very small. There are literally thousands of individual mines (3,800 in 1989) ranging in size from a surface mine in Wyoming which produces nearly 30 million tons per year to mines that extract only a few thousand tons annually. The fifty largest mines in the country, accounting for nearly one-third of the nation's output, each produce at least 3 million tons annually, and yet the average size of a U.S. coal mine in 1988 was only 265,000 tons. Truly, the U.S. coal industry is one of contrasts.

Ownership within the industry is equally diverse, ranging from individual entrepreneurs to some of the nation's largest corporations. Of the top twenty coal companies, representing over 50 percent of the coal industry output (Table 1), all are subsidiaries or affiliates of other energy, mining or diversified interests.

MAJOR U.S. COAL PRODUCERS, 1989

(Million Short Tons)

	Tonnage	Pct. Of Total Production
1. **Peabody Holding Group** (Hanson Industries)	86.7	8.9
2. **Consolidation Coal Company** (E.I. DuPont de Nemours)	53.5	5.5
3. **AMAX Coal Industries Inc.** (AMAX Inc.)	38.4	3.9
4. **ARCO Coal Company** (Atlantic Richfield Company)	31.1	3.2
5. **Texas Utilities Mining Company** (Texas Utilities Company)	29.9	3.1
6. **Exxon Coal and Minerals Company** (Exxon Corporation)	28.1	2.9
7. **Shell Mining Company** (Royal Dutch Shell)	25.5	2.6
8. **NERCO** (Pacific Corp)	24.5	2.5
9. **Sun Coal Company** (Sun Company, Inc.)	22.8	2.3
10. **North America Coal Corporation** (NAACO, Inc.)	22.5	2.3
11. **Western Energy Company** (Montana Power Company)	21.8	2.2
12. **Island Creek Corporation** (Occidental Petroleum Corporation)	19.6	2.0
13. **Arch Mineral Corporation** (Ashland Oil; Hunt Petroleum Inc.; Hunt Industries)	18.9	1.9
14. **Kerr-McGee Coal Corporation** (Kerr-McGee Corporation)	17.6	1.8
15. **A.T. Massey Coal Co.'s Sub.** (Fluor Corporation)	16.9	1.7
16. **Kiewit Mining Group** (Peter Kiewit Sons Co.)	15.9	1.6
17. **BHP-Utah Minerals** (Broken Hill Proprietary Co., Inc.)	15.2	1.6
18. **Pittsburg and Midway** (Chevron Corporation)	15.1	1.5
19. **Cyprus Coal Company** (Cyprus Mineral Corporation)	14.2	1.5
20. **Coastal Coal** (Coastal Corporation)	13.4	1.4

(TABLE 1)

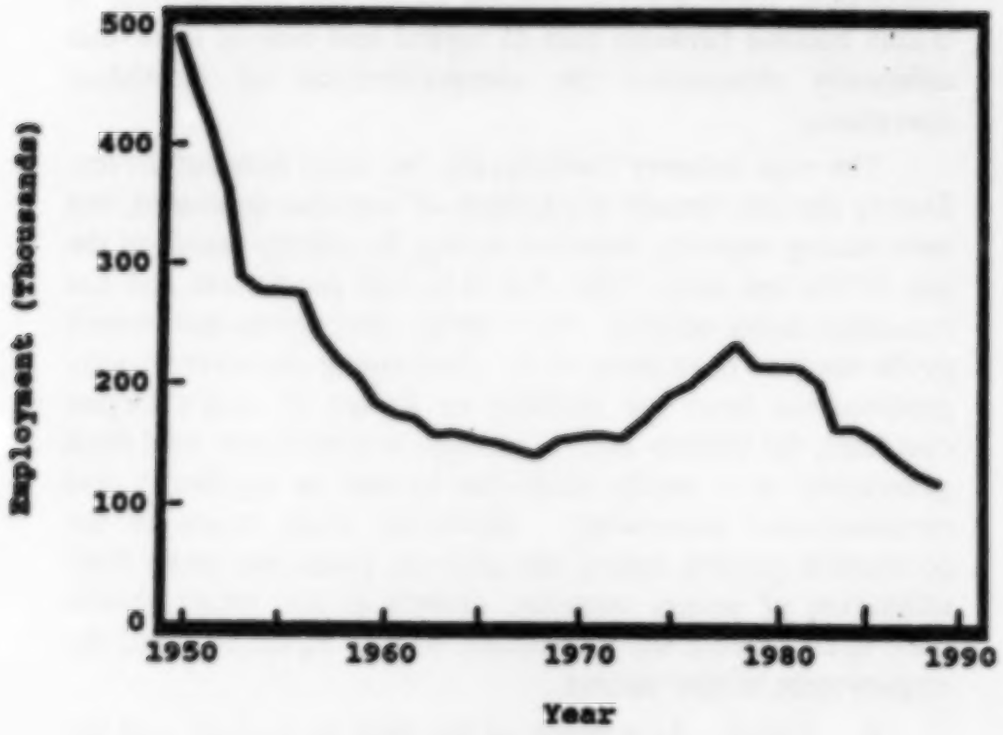
Coal mining today can be both capital and labor intensive. Major mining systems and individual pieces of equipment can cost millions of dollars each but the labor component, particularly at smaller mines, can also be high. It is this balance between cost of capital and cost of labor that ultimately determines the competitiveness of individual operations.

The coal industry traditionally has been demand driven. During the last decade production of coal has increased, but new mining capacity installed during the energy boom of the late 1970s and early 1980s has outpaced production and has remained under utilized. As a result, coal prices and overall profit margins have been weak. Prolonging this overcapacity problem has been the inability or failure of coal's largest customer, the electric utility industry, to install new coal fired generation on a timely basis due in part to regulatory and environmental uncertainty. However, while much of the production growth during the past ten years has come from utilization of excess capacity, growth in the future should once again require the installation of new equipment and the employment of new miners.

E. Labor. As a result of the shift in markets and the rapid mechanization of U.S. mines during the 1950s and 1960s, coal mine employment declined 75 percent during this period from a high of 488,000 in 1950 to 130,000 by 1969. (Figure 2) This downward tend was reversed during the 1970s due to increased production but mainly in response to new federal and state legislation regulating coal mine safety and mined land reclamation.

However, beginning in the late 1970s and throughout the 1980s, the downward trend has resumed and coal mine employment today is at a post-war low despite record levels of production.

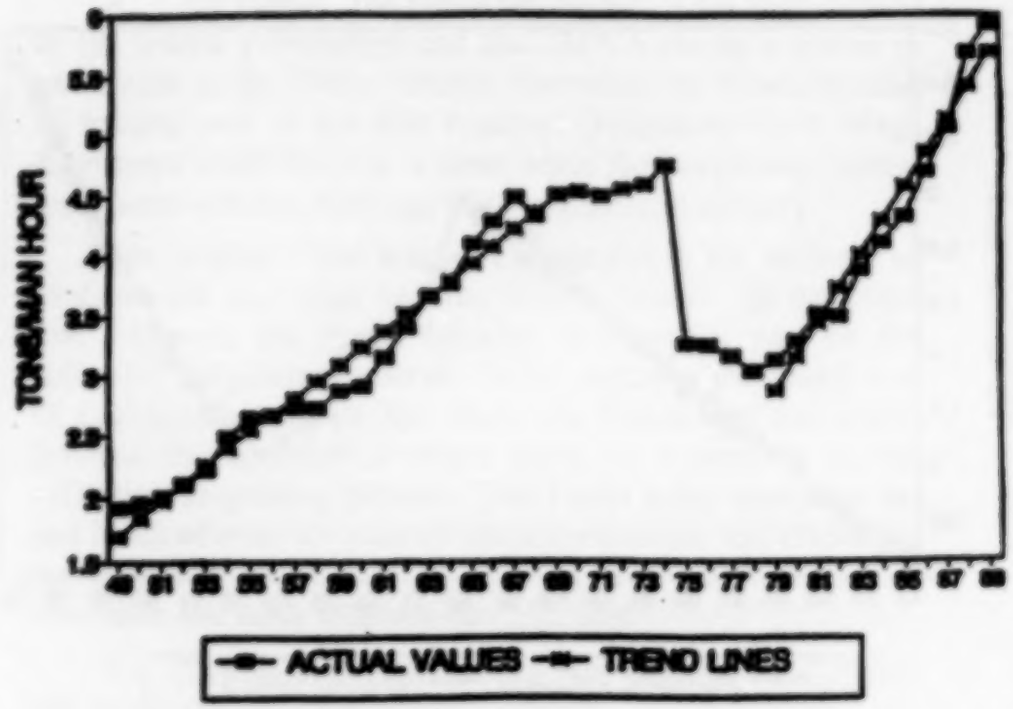
U.S. Coal Mine Employment
1950 – 1988



(FIGURE 2)

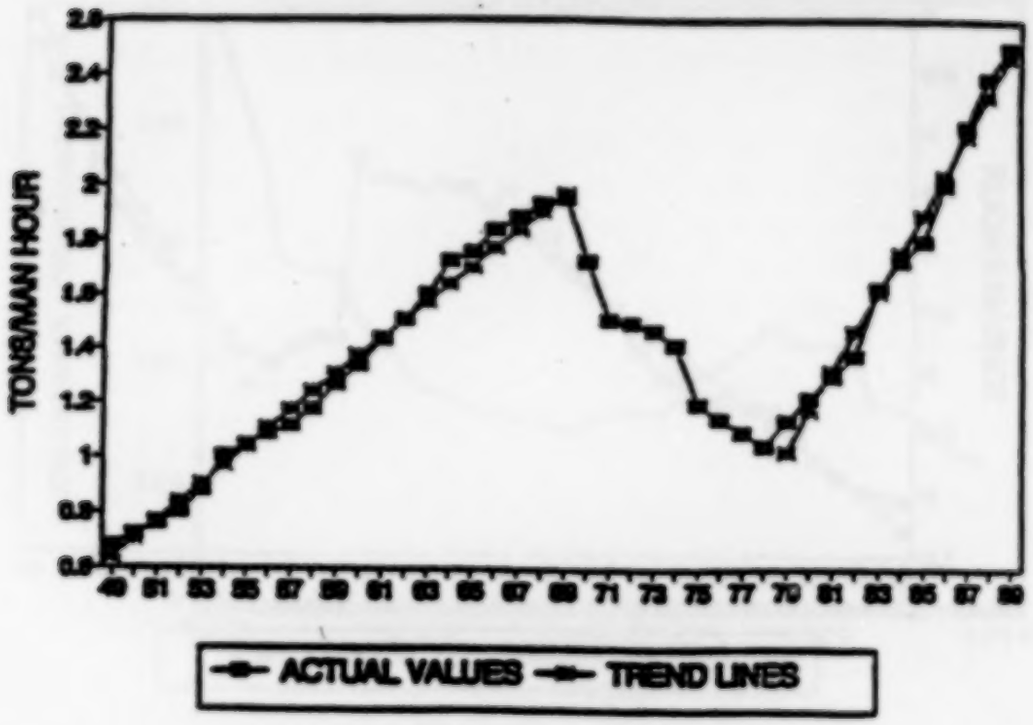
From 1950 through 1969, coal mine productivity grew steadily but then declined during the 1970s as a result of the new federal and state laws and regulations. However, during the 1980s that trend has been reversed and industry-wide productivity has increased at a rate of over 8 percent per year during the past decade. (FIGURES 3 & 4)

PRODUCTIVITY IN SURFACE MINES
(ALL EMPLOYEES)



(FIGURE 3)

PRODUCTIVITY IN DEEP MINES
(ALL EMPLOYEES)



(FIGURE 4)

As mining operations and equipment have become more technical and complex, there has been a corresponding change in the work force. Today's miner is likely to be older, better educated, better paid and has about ten years' experience with the same company. In addition, women miners are common today. A coal miner's average annual income is about $35,000 and can be considerably higher with normal overtime and bonuses. Health and welfare benefits rank among the best in U.S. industry. In short, coal miners today are among America's most highly trained, skilled and best paid industrial workers.

CHAPTER TWO

HISTORY OF THE FUNDS[1]

A. The Funds. The Funds are unique. They were created by the federal government and the UMWA during a period of labor strife in the 1940s. Shortly thereafter, the Funds became an integral part of the first National Bituminous Coal Wage Agreement (NBCWA) at a time when the bargaining parties were faced with the challenge of saving the coal industry.

The original Fund was an experiment in the delivery of medical care and other benefits to coal miners. In the years that followed, the Funds became an essential part of the collective bargaining process. More recently, the rising cost of health care benefits has made the Funds and the health benefits they provide a major point of contention in the collective bargaining process. The Funds today represent the end result of over 40 years of historic evolution and efforts by the parties to fit a medical care system into a changing economic and labor relations environment.

B. Historical Development. The history of the Funds can be divided into five distinct periods:

- The period of establishment and its historical underpinnings, which saw two factors, the Union's desire for improved medical care for coal miners and labor-management strife, come together in 1946 to establish the Fund. The Fund's administration was fraught with problems and disagreements between the Union and Operator Trustees.

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[1] The material on the History of the Health Care Benefits in the Bituminous Coal Industry was prepared and presented to the Coal Commission by Richard L. Trumka, International President of the United Mine Workers of America, and Joseph P. Brennan, President of the Bituminous Coal Operators' Association, Inc. Some Commission members do not believe that the government is responsible for the Funds' present financial crisis or that it is necessary for the government to be involved in resolving the present crisis.

- The period of development, stretching from 1950 to 1960, which saw the growth of the Funds and its medical care delivery philosophy and infra-structure that in many ways continues to dominate much of their operations.
- The period of retrenchment, during the decade of the 1960s, as economic reality came in conflict with institutional goals. During this period, many of the major initiatives of the earlier years were discarded, eligibility rules were scaled back, and the Fund faced the possibility that its historic mission might not be achieved.
- The period of transition ran roughly through the 1970s. Employer involvement increased. The law demanded fundamental change, especially as it related to pensions; change that came to dominate the attention of the bargaining parties for much of the decade. The Funds moved from being the provider of medical care for all miners to essentially a program for certain retirees.
- The period of crisis covers the 1980s to the present. During the 1980s, the Pension Funds flourished, but the medical care program became increasingly contentious. During this same period, the contribution base declined even though national coal production increased substantially. In the 1980s, medical care costs also rose rapidly, even though cost containment was a major objective of the parties. The net result is that the Health Benefit Funds are now facing a financial crisis.

Four common factors run through the history of the UMWA Funds. Each of them separately and together have contributed to the evolution of the Funds. These factors are (1) government involvement; (2) the collective bargaining process; (3) the medical care delivery system; and (4) the industry.

1. Period of Establishment. The period of establishment covers the system of medical benefits in place before the Fund and the efforts made by the Union to establish it that culminated in the historic Krug-Lewis Agreement.

a. Medical Care Delivery System. Prior to the creation of the UMWA Welfare and Retirement Funds, medical care in coal field communities consisted of a prepaid system based on deductions from the miners' paychecks. Under this system the coal company deducted money from wages and hired doctors to provide medical services to the miners. In many cases this was necessary because the isolated, rural areas where coal was produced did not attract medical professionals and only the lure of a guaranteed income could induce doctors to set up practice in coal mining communities. Over time, the company doctor system developed in ways that the miners felt were not in their best interests.

Because of nationwide concern about health care matters during the Great Depression, President Roosevelt in 1935 appointed an Inter-departmental Committee to Coordinate Health and Welfare Activities. He named as chairman of the committee Josephine Roche, who later became the Neutral Trustee and Executive Director of the Fund. One of the major activities of the committee was to convene a National Health Conference, at which Dr. Walter Polakov, Director of the UMWA Department of Engineering, called for the establishment of "group medicine and group hospitalization" in coal mining communities.

Based on Dr. Polakov's presentation, the Union, through the Good Will Fund of Boston and the Twentieth Century Fund of New York, commissioned a report on medical conditions in the coal field communities by the Bureau of Cooperative Medicine. The study concluded that there was a pressing need for medical care reform in the coal fields.

b. Government Involvement and Collective Bargaining. With the end of the Second World War, Union negotiators renewed their efforts for medical care reform. When negotiations opened in 1945, the UMWA proposed a royalty of 10 cents per ton of coal to be paid to the Union to "provide for

its members modern medical and surgical service, hospitalization, insurance, rehabilitation and economic protection." Although this was a new concept in America, a precedent existed in Great Britain where a welfare fund had been created in 1920, financed by royalties on coal production.

The operators rejected the participating royalty. The proposal ultimately was dropped when Secretary of Labor Frances Perkins entered the negotiations. She met with both sides and offered a compromise that did not include a royalty. The Union accepted the Secretary's compromise suggestion and dropped the medical care proposal until the next round of negotiations.

When the National Bituminous Wage Conference convened in 1946, a health and welfare fund for miners was the Union's top priority. The operators again rejected the proposal and the miners walked off the job on April 1, 1946. Negotiations under the auspices of the U. S. Department of Labor continued sporadically through April. On May 10, 1946, President Truman summoned John L. Lewis and Charles O'Neill, chief spokesman for the northern operators, to the White House. The stalemate appeared to break when the White House announced an agreement in principle on a health and welfare fund.

Despite the announcement by the White House, the operators still would not agree to the creation of a fund. Another conference at the White House failed to forge an agreement and the negotiations again collapsed.

Faced with the prospect of a long strike, President Truman issued an Executive Order directing the Secretary of the Interior to take possession of all bituminous coal mines in the United States and to negotiate with the Union "appropriate changes in the terms and conditions of employment." Secretary of the Interior Julius Krug seized the mines the following day and ordered the miners back to work. The miners refused, and negotiations between the UMWA and the federal government continued, first at the Interior Department and then at the White House with President Truman participating in several conferences.

After a week of negotiations, the historic Krug-Lewis agreement was announced and the strike ended. It created a welfare and retirement fund to make payments to miners and their dependents and survivors in cases of sickness, permanent disability, death or retirement, and other welfare purposes determined by the Trustees. The fund was to be managed by three Trustees, one to be appointed by the federal government, one to be appointed by the UMWA, and the third chosen by the other two. Financing for the new fund was to derive from a royalty of 5 cents per ton of coal produced for use or sale.

The Krug-Lewis agreement also created a separate medical and hospital fund to be administered by Trustees appointed by the UMWA. The purpose of the fund was to provide for medical, hospital, and related services for the miners and their dependents.

The Krug-Lewis agreement also committed the federal government to undertake "a comprehensive survey and study of the hospital and medical facilities, medical treatment, sanitary, and housing conditions in coal mining areas." The expressed purpose was to determine what improvements were necessary to bring the coal field communities into conformity with "recognized American standards." It was the first nationwide medical survey of an industry ever conducted by the United States government.

To conduct the study, the Secretary chose Rear Admiral Joel T. Boone of the United States Navy Medical Corps. Federal government medical specialists spent nearly a year in the various coal fields of the nation exploring the medical care system. Their report, "The Medical Survey of the Bituminous Coal Industry," found that, in coal field communities, "provisions for health range from excellent, on a par with America's most progressive communities, to very poor, their tolerance a disgrace to a nation to which the world looks for pattern and guidance." The survey team discovered that "three-fourths of the hospitals are inadequate with regard to one or more of the following: surgical rooms, delivery rooms, labor rooms, nurseries and x-ray facilities." The study

concluded that "the present practice of medicine in the coal fields on a contract basis cannot be supported. They are synonymous with many abuses. They are undesirable and in many instances deplorable."

Thus, the Boone Report not only confirmed earlier reports of conditions in the coal mining communities, but also established a strong federal government interest in correcting long-standing inadequacies in medical care delivery. Perhaps most important, it provided a road map for the newly created UMWA Fund to begin the process of reform.

Shortly after the Boone Report was issued, the mines were returned to their private owners and a new National Bituminous Coal contract was executed. It combined the pension and medical programs and increased the royalties to 10 cents per ton of coal. Thus began a two-year struggle over activation of the pension program. While the level of the pension benefit and various eligibility issues were in dispute, there was also a major disagreement over whether the Fund should be on a pay-as-you-go or a pre-funded basis. After seven months of stalemate, the Neutral Trustee resigned in frustration.

The failure to agree on pensions caused miners to walk out of the mines in March 1948. Recognizing the intractability of the situation, the Speaker of the U. S. House of Representatives, Joseph Martin, asked the Trustees to meet with him on April 10, 1948. At the meeting in the Capitol, Speaker Martin suggested Senator Styles Bridges of New Hampshire as a neutral Trustee. Both Trustees agreed to the Speaker's suggestion. Senator Bridges pointed out the delay of almost two years since the Krug-Lewis agreement. He proposed to set the retirement age at 62 with 20 years of service and retirement subsequent to the Krug-Lewis agreement. By a vote of Lewis and Bridges the resolution was adopted and the deadlock was broken. Thus the Fund pension program was placed on a pay-as-you-go basis.

2. Period of Development. The 1950s saw a period of labor management cooperation and significant changes in the

way coal was mined. During this period the medical program of the Fund was fully developed.

a. Collective Bargaining Process. The development of the current medical care system is directly tied to the relationship between the parties. The 1950 Wage Agreement marked the beginning of a period of cooperation which had as its basic premise, a concordat between the UMWA and the coal industry that the Fund would move forward and operators would be able to mechanize their mines. A long period of relative labor-management peace ensued as both parties recognized that cooperation was essential to the long term viability of the coal industry.

b. Medical Care Delivery System. Ten regional offices were established throughout the coal fields, with the direction to make arrangements with local doctors and hospitals for the provision of "the highest standard of medical service at the lowest possible cost."

One of the first programs initiated by the Fund was a rehabilitation program for severely disabled miners. Under this program, over 1,200 severely disabled miners were rehabilitated. The Fund searched the coal fields to locate the disabled miners and sent them to the finest rehabilitation centers in the United States. At those centers, disabled miners received the best treatment that modern medicine and surgery had to offer, including artificial limbs and extensive physical therapy to teach them how to walk again. After a period of physical restoration, the miners received occupational therapy so they could provide for their families.

The Fund also made great strides in improving overall medical care in coal mining communities, especially in Southern Appalachia. Recognizing the need for modern hospital and clinic facilities in the coal fields, the Fund constructed and operated ten hospitals in Kentucky, West Virginia and Virginia. The hospitals, known as Miners Memorial Hospitals, provided intern and residency programs and training for professional and practical nurses.

c. Government Involvement. Government involvement in the developmental phase of the Funds was evident in their programs. The doctors recruited to administer the medical care program were, for the most part, former officials of the U. S. Public Health Service. The program which they established, both with respect to delivery and scope of coverage, reflected the views of those seeking much greater government involvement and a restructuring of the health care delivery system.

In addition, the Fund was not a qualified trust under the Internal Revenue Code. As a result, Fund income beyond the level of administrative expenses was deemed taxable. Moreover, employer contributions were not deductible. To correct this a special section was inserted in the Internal Revenue Code in 1954 that permitted the deduction of employer contributions to a trust fund established under circumscribed conditions, one of which was government sponsorship.

d. Industry. After World War II, railroads converted to diesel locomotives; the home heating market was all but lost; natural gas pipelines were constructed; and imported oil began to flow into the country, further eroding coal's markets. As a result, the amount of coal produced fell sharply and the number of miners working dropped drastically. In 1945, 383,000 mine workers produced nearly 578 million tons of coal. By 1960, it took only 169,400 miners to produce nearly 416 million tons of coal.

The economic situation caused two interconnected problems for the Fund and the Miners Memorial Hospitals. First, the sharp reduction in coal output caused financial problems as royalty income fell. Second, the loss of over 200,000 miners drastically reduced the potential number of Fund patients to utilize the services of the new hospitals. Thus, the hospitals had to rely on non-Fund beneficiary patients to meet economies of scale, placing them in direct, and often bitter, competition with other hospitals and local medical societies.

3. Period of Retrenchment. By the 1960s, the difficult economics of the coal industry forced the Fund to take actions to meet financial realities.

a. Government Involvement and the Medical Delivery System. The economic decline of the coal industry forced the Fund to sell the hospitals. Again, the federal government was to play an important role. The United Presbyterian Church approached the Fund with an offer to buy the hospitals, but the purchase was contingent on receiving federal funds from the U. S. Department of Commerce. Eventually, with the help of Assistant Secretary of Labor Daniel Patrick Moynihan and the personal involvement of President Kennedy, federal funds were made available and the hospitals were sold. Although they were no longer owned and controlled by the Funds, they continued to serve miners and other residents of the coal field communities and contributed to a significant improvement in overall medical care.

b. Collective Bargaining Process. Collective bargaining in the beginning of this period saw a continuation of the cooperative efforts that began in 1950. The latter part of the decade, however, saw a resumption of tensions at the bargaining table as the industry began to revive.

In the coal fields there had been wildcat strikes as a result of the retrenchment actions by the Trustees, particularly with respect to eligibility for a health card. For example, in 1960, the Trustees ruled that unemployed miners could only have health cards for one year and from 1962 to 1966 health cards were taken from the employees of companies with delinquent contributions. Both health and retirement benefits were paid from a single trust. Economic realities forced the Trustees to make decisions on the level of benefits. Health care benefits were paid first, retirement benefits were paid last and were not guaranteed. If coal production dropped and there was not enough money in the Fund to pay the "target level" retirement benefit, the amount of the retirement benefit was reduced. In slow times money was diverted from the retirement payments to pay for health care benefits.

c. Industry. Employment levels bottomed out at 124,500 working miners in 1969 as compared to the 415,600 in 1950. Toward the latter part of the decade, there was an unrecognized turn in the fortunes of coal because of the increasing demand by the utilities for energy. But such growth was not a straight line projection of the past. Western production was becoming significant, surface mining was growing, and the potential of coal was attracting large sources of capital outside of the traditional coal industry.

d. Government Involvement. Congress and many state legislatures passed laws on prevention, treatment and compensation for Black Lung which would cost billions of dollars. Moreover, the designation of Black Lung as an occupational disease shifted the medical costs connected with the disease from the Fund to the Black Lung Trust or individual employers, although the cost impact would not be felt for years.

Coal mine health and safety concerns led to the passage of the Coal Mine Health and Safety Act of 1969.

4. Period of Transition. The decade of the 1970s was a period of change for the Funds, the coal industry, and the UMWA. It was characterized by the rapid growth of coal mining nationally, significant changes in health, safety and environmental regulations, and the entry into the work force of a new generation of coal miners. In addition, the Employee Retirement Income Security Act of 1974 (ERISA) became law, imposing significant costs and administrative burdens on the Funds.

a. Collective Bargaining Process. After the death of John L. Lewis in 1969, the Funds once again became a central bargaining issue between the parties. Benefit levels, particularly pensions, were looked upon by the new young work force as being low. Employers became more and more aware of the cost implications of the Fund and the role that it would play in future labor-management relations.

From the 1971 negotiations forward, there was heavy involvement by both settlors on all aspects of the Funds'

operation. The parties monitored Fund administration through oversight of the Trustees and in setting benefit levels and eligibility criteria at the bargaining table. There were several reasons for the shift toward more settlor involvement.

First, the total cost of the programs increased as the number of beneficiaries grew and inflation became a constant.

Second, the legal terrain changed dramatically, especially with pensions, creating a permanent obligation where there was previously none. The intervention of the federal judiciary, especially in Boyle v. Blankenship, Kiser v. Huge, etc., 329 F. Supp. 1089 (D.C.C. 1971), aff'd. 511 F.2d 447 (D.C.C. 1975), overruled many of the eligibility and administrative actions by the Trustees and added nearly 19,000 retired miners to the Fund, many of whom spent a considerable amount of their work careers in nonunion mines. In addition, the new group of retired miners brought thousands of dependents eligible for health care with them.

And, third, the dramatic influx of new workers in the early 1970s suggested a review and a revamping of the pension and benefits programs to meet the needs of these younger workers.

In response to these forces, the 1974 Agreement restructured the Fund into four separate Trusts -- two for pre-1976 retirees, the 1950 Pension and 1950 Benefit Plans, and two for post-1975 retirees and the active work force, the 1974 Pension and 1974 Benefit Plans. The new plans also established a negotiated plan of benefits removing Trustee discretion to set benefit levels and eligibility standards.

The enormous overhang of pension liability of the post-ERISA period mandated a close working relationship between the parties. The parties agreed on a rapid funding schedule for the 1950 Pension Plan, a schedule that resulted in full funding of that Plan in 1987. The newly created ongoing liability of the 1974 Plan was to be funded on an hourly contribution basis.

b. Industry. The decade of the 1970s saw a major turn around for the coal industry in terms of production,

employment, and future potential. The impact on the Funds was threefold: first, the new growth potential offered the prospect of financial stability after two decades of stagnation and decline; second, there was an influx of young coal miners with expectations considerably higher than their grandfathers; and, third, a whole generation of miners retired. This occurred at a time when pension and medical care costs began to escalate and contractual pension obligations became fixed by statute.

But the most compelling feature of the period was the decline in the relative national share of NBCWA tonnage. The coal industry was being altered in a major way. New investors came into the coal industry who often were not interested in old established relationships and were unwilling to participate in the Funds. The new mines in the west were highly productive and did not want to subsidize their low productivity competitors. If there was to be a relationship with the UMWA, they wanted it to be outside the national agreement.

In this environment, the NBCWA also came under sharp attack from the signatories, and more and more attention came to be focused on the health and retirement system. One of the mutual responses to this trend by the UMWA and the BCOA was to fund the pensions as rapidly as possible to make them immune from economic trends in the industry. This effort was successful.

c. Medical Care Delivery System. In the 1970s, sharply increasing costs focused concern on the Funds. During the term of the 1974 NBCWA, contributions were reallocated among the various trusts in an effort to maintain the benefit stream. But the Funds fell into serious financial difficulty, leading to the reduction of medical benefits and eventually a total cutoff during the strike at the expiration of the Agreement. This first ever reduction of medical benefits resulted in a massive unauthorized work stoppage during the summer of 1977.

d. Government Involvement. The 1971 negotiations took place during wage and price controls and the agreement

had to be approved by the government. Both sides worked together to win government approval because the 15 percent increase in labor costs exceeded the Government's wage guidelines. The government approved the 15 percent wage increase and the doubling of the contribution rate to 80 cents per ton. However, it did not agree to allow an increase in the price of coal to the consumer to pass through the increase in the contribution rate as agreed by the parties.

5. Period of Crisis. The strains of the 1974 Agreement were carried forward into the 1978 negotiations. The Funds, especially the Benefit Plans, have been a matter of concern to the parties ever since.

a. Collective Bargaining and the Delivery System. Both parties entered the negotiations in 1977 with definite ideas on health care issues. The BCOA proposed individual company health plans and the UMWA wanted a guarantee that health benefits would not be cut in the future. Failure to reach agreement on these and many other issues caused an 111-day contract strike. Once again the federal government was involved; the White House intervened in the dispute and negotiations were conducted in the Secretary of Labor's office.

Under the 1978 agreement the Funds ceased to provide medical benefits to all beneficiaries; responsibility for active miners and for post-1975 retirees shifted to the individual companies as part of a broad agreement that also restored and guaranteed the benefits and introduced the so-called "evergreen clause" or continuing contribution obligation into the Agreement. This clause is currently in litigation. The 1974 Benefit Trust remained as a Fund for retirees whose last employer had gone out of business. The meaning of this eligibility language is in dispute and also is in litigation.

For the Funds' beneficiaries the changes were far more basic. Beneficiaries had freedom of choice in selecting medical care providers, effectively ending the clinic system and participating physicians and hospitals. A new program was established covering acute drug needs.

The Trustees, in addition to their role as administrators, were to act as arbitrators in the company health plans to ensure that active miners and retirees on company plans would receive the same level of benefits as those beneficiaries on the Funds' rolls. This arbitration arrangement has been sanctioned by the Department of Labor since it was put into place in 1979.

The disparity in the levels of productivity between bituminous and sub-bituminous western mines also led to a negotiated agreement between some western coal operators and the UMWA. Under the terms of the Western Coal Wage Agreement of 1978, western coal companies agreed to create company-based health care and retirement funds which provided benefits that were as good as or better than the benefits provided under UMWA Health and Retirement Funds. Retirees in the Funds from those companies became the liability of the western mine operators, who then were relieved from the obligation to make further contributions to the UMWA Health and Retirement Funds.

In the 1980s there has been a struggle for Fund survival. Contractually, the parties have focused on cost and quality control. In 1984, a specific commitment to jointly address costs was written into the agreement. The 1988 Agreement mandated that the Trustees develop and implement an industry wide fee schedule and continue other cost control programs such as: inpatient hospital pre-admission and length of stay reviews; case management and quality of care programs; an aggressive prescription drug program; and other initiatives that result in no loss or reduction of benefits to participants.

b. Industry. Overshadowing the delivery vehicle have been the cost implications and the labor relations impact of the Funds. By the early 1980s NBCWA tonnage had slipped to close to 40 percent of national production, down from the approximately 80 percent levels when the Fund began. Today it has dropped to about 30 percent as the growth of non-NBCWA coal continued throughout the 1980s. Companies withdrew from

BCOA and sought to individualize their bargaining relationship, often in an effort to end their financial obligations to the Funds.

c. Role of Government. As a result of the 1977-78 dispute, President Carter appointed a Presidential Coal Commission to examine the issues that had lead to the bitter strike, including "health, safety and living conditions in the Nation's coal fields." The Commission found that health care indeed had improved in the coal fields. "Conditions since the Boone Report have changed dramatically, largely because of the efforts of the miners and their Union – but also because of contributions by the Federal Government, State and coal companies." And the benefit of the Funds' program was not limited solely to the immediate beneficiaries. The Commission concluded that "both union and non-union miners have gained better health care from the systems developed for the UMWA".

In 1980, the Congress passed the Multi-Employer Pension Plan Amendments Act (MPPAA) to ERISA. The UMWA and the BCOA strongly supported the passage of MPPAA which embodied the concept of withdrawal liability. In the legislation which ultimately passed, there are special sections for the 1950 Pension Plan based upon its unique nature and the circumstances surrounding its inception.

In 1989, Senators Rockefeller, Heinz, Byrd and Specter introduced legislation to stabilize the funding base of the benefit funds. Included in this legislation was authority to transfer the over funded portion of the 1950 Pension Trust to the Benefit Trusts.

The impact of government upon the Funds has not been limited to the executive and legislative branches. Court decisions too have had major impacts, good and bad, upon the Funds and their solvency. Two are illustrative of the problems.

As noted, the court's decision in Blankenship dealt with the issues of alleged mismanagement of the Fund's finances and arbitrary changes to eligibility standards. In Blankenship, Judge Gesell in 1971 ordered the removal of Union and Neutral Trustees and appointment of a new neutral trustee. He also ordered the appointment of an independent financial advisor and

directed that investments be made only in the interest of participants and beneficiaries.

The Royal/Nobel line of cases is still pending before the Courts. Those decisions have added thousands of former miners to the 1974 Benefit Fund with significant financial costs. This matter represents a serious dispute between the parties.

The medical care delivery system that has evolved is as much a creature of government as it is of the collective bargaining process. There is a line running from the original Boone Report to the present system. In a way, the original Krug-Lewis agreement predisposed if not predetermined the system that evolved.

d. Funds Today. Today, the Funds remain a major purchaser of medical care, but the development of health care is now a much broader community effort with the coal industry being only one part of the system.

The Funds should be viewed as a microcosm of the broader national dilemma over retiree health care. This financial crisis not only has the potential to jeopardize necessary health care benefits for retirees, it also threatens the relationship between labor and management in the coal industry. The challenge is to find ways to cope with the present crisis in the medical care delivery system started by a collective bargaining agreement negotiated between the UMWA and the coal operators, with help from the Federal Government, four and one-half decades ago.[2]

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[2] See Appendix 3 for a history of the contribution levels from 1946 to the present.

COVERAGE OF THE FUNDS

A. Coverage. As early as the 1950s the United Mine Workers of America and the major bituminous coal operators negotiated labor contracts that included employer contributions into a jointly administered central health care fund for active and disabled miners, retirees and dependents.

In 1974 the UMWA and the Bituminous Coal Operators' Association (BCOA), representing major coal producers, agreed to the establishment of two separate health benefit funds to be administered by independent trustees. One (the 1950 Benefit Plan) would be a closed fund for miners and dependents who retired prior to 1976, while the second, the 1974 Health Benefit Plan, would cover health care for active and disabled miners, dependents, and those retiring after 1975. Each would be funded by employer contributions at levels established through collective bargaining. Obligations under the 1950 Benefit Plan would continue to be funded on tonnage-based contributions. Obligations under the 1974 Benefit Plan were to be funded on an hours-based formula.

In 1978 the UMWA and BCOA agreed that health care for active miners, future retirees and dependents would become the responsibility of single employers rather than the central funds. The level of benefits would remain the same but the operators would be free to set up individual plans for this coverage. The operators would continue to make contributions to the 1950 Benefit Plan at levels adequate to fund health care coverage for those miners who retired prior to 1976 and would provide individual health benefits for their active miners, their post-1975 retirees and dependents. The 1974 Benefit Plan would be retained for the purpose of providing health care for those retirees and dependents whose last employer was "no longer in business."

Today, the UMWA Health and Retirement Funds are structured as follows:

1. 1950 Pension Plan. The 1950 Pension Plan provides retirement benefits to miners who retired before December 31, 1975 and to those "who became disabled after May 28, 1946,

and before December 6, 1974, as the result of a mine accident."[3] In addition the 1950 Pension Plan provides retirement benefits to the widows and beneficiaries of retired or disabled UMWA coal miners who are eligible to receive retirement benefits under the 1950 Plan.

2. 1950 Benefit Plan. The 1950 Benefit Plan provides health care benefits for "retired and disabled mine workers who receive pensions from the 1950 Pension Plan."[4] The 1950 Benefit Plan also provides health care benefits to the dependents of retired or disabled mine workers who receive retirement benefits from the 1950 Pension Plan. In addition, the 1950 Benefit Plan "provides health and death benefits to the eligible survivors of retired or disabled UMWA mine workers."[5] In some instances, the 1950 Benefit Plan also provides health care benefits for "disabled mine workers under the age of fifty-five who do not qualify for disability pensions but who will qualify for retirement pensions upon reaching the age of fifty-five."[6] The 1950 Benefit Plan also provides for the payment of death benefits "to eligible surviving dependents of deceased pensioners or to the estates of deceased pensioners who are not survived by eligible dependents."[7]

3. 1974 Pension Plan. The 1974 Pension Plan provides retirement benefits to UMWA coal miners who retire after December 31, 1975. The 1974 Pension Plan also provides retirement benefits to UMWA coal miners "who became disabled after December 5, 1974, as the result of a mine accident."[8] In addition, the 1974 Pension Plan provides retirement benefits to the widows and beneficiaries of retired or

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[3] Summary Plan Description, 1950 Pension Plan and Trust; 1950 Benefit Plan and Trust, United Mine Workers of America Health and Retirement Funds (undated).

[4] Id.

[5] Id.

[6] Id.

[7] Id. at 3.

[8] Summary Plan Description, 1974 Pension Plan and Trust, United Mine Workers of America Health and Retirement Funds (undated).

disabled coal miners who are eligible to receive retirement benefits under the 1974 Plan.

4. 1974 Benefit Plan. The 1974 Benefit Plan provides health care and death benefits only to UMWA coal miners whose companies are no longer in business. The 1974 Benefit Plan also provides health care and death benefits to the dependents and the spouses of such miners.

B. Comparison with Other Plans. A comparison of the health care and retirement benefits received by UMWA members with those received by members of the United Auto Workers (UAW) and the United Steelworkers of America (USWA) reveals similarities and some differences.[9] On the whole, the health care benefits received by UMWA members are far more comprehensive than health care benefits received by UAW and USWA members; nor does the UMWA plan require deduction or coinsurance. However, the retirement benefits received by UMWA members tend to be less than the retirement benefits received by UAW and USWA members. A detailed comparison of the health care benefits available under each plan is set forth in Figure 5.

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[9] The data comparing the health care benefits received by members of the UMWA with the types of health care benefits received by members of the United Auto Workers and members of the United Steel Workers of America was prepared by Micheal Buckner, Research Director at the United Mine Workers of America, and Bruce C. Swan, Administrative Assistant to the Chairman, Bethlehem Steel Corporation.

(FIGURE 5)

UMWA/USWA/UAW

Retiree Health Benefits Comparison

	UMWA	USWA*	UAW
Type of Plan	Comprehensive	Basic/Major Medical	Basic/Catastrophic Medical
Dependent Coverage	Spouse, unmarried children under 22 years of age, parents living in the same household, unmarried grand-children living in the house under age 22, or disabled dependent.	Spouse, unmarried children under 19 years of age (or under 25 years of age if full-time student), or disabled dependant.	Same as USWA, except covered to age 25, if a dependent for tax purposes.
Medical Necessity Language	Yes	Yes	Yes
Deductibles	None	None on basic. Optional Major Medical* $100 individual $200 family	None on basic. Major Medical $100 individual 2 deductibles/family
Copays	Physician Services Only $5.00/visit Prescriptions: $5.00/prescription	None on basic. Major Medical 20%	None on basic. Major $100 individual 2 deductibles/family
Annual Maximum	None	Major Medical: $30,000	None
Annual Out-of-Pocket Cap	$150/family	None	Major Medical: $2,000
Lifetime Maximum	None	Major Medical: $50,000	Major Medical: $50,000
Reinstatement Provisions	N/A	$1,000/calendar year	N/A

* Optional Major Medical program is and optional program and requires retiree contributions.

BENEFITS DESCRIPTION	UMWA	USWA	UAW
Hospital Coverage - Basic			
Managed Care	Hospital Pre-certification Concurrent Review Discharge Planning Select Surgeon Program Physician UR Prescription Drug UR Catastrophic Case Management	Yes. Pre-certification required for the following: Hospitals, including rehab facilities; Skilled Nursing or Extended Care facilities; Psychiatric Care (Inpatient and Outpatient) Home Health Care Emergency Admissions to be certified within 48 hours	None
Non-Compliance Penalty	N/A	$100.00	N/A
INPATIENT			
Inpatient Days Available	Unlimited	120 days per admission	365 days/hospitalization
Non-participating Hospital Payment	N/A	$25 for the first day $10 thereafter	N/A
Mental/Nervous	Up to 60 days treatment (does not include A&D)	30 Days during any 12-month period	45 days; renewed after 60 days of no confinement
Alcohol and Drug Detox and Rehab	7 calendar days for Detox	Not Covered	45 days; renewed after 60 days of no confinement
Dental Services	Covered, but only for limited oral surgical procedures.	Covered if certified by the physician that hospitalization is medically necessary to safeguard the health of the patient.	Same as USWA
Maternity	Covered – 100% Coverage for newborn child	Covered – 100% Coverage for newborn child limited to the first 10 days. Birthing Centers also covered.	Covered – 100% (Includes routine nursery care of newborns.)

BENEFITS DESCRIPTION	UMWA	USWA	UAW
Hospital Coverage - Basic			
OUTPATIENT			
Alcohol & Drug	Covered	Not Covered	100% of R&C-first 5 visits; patient pays 10% of charge thereafter; $1,000 annual maximum
Dental Services	Same as inpatient dental	Covered if medically necessary to safeguard the health of the patient	Same as USWA
Emergency Accident	Initial treatment within 48 hours of accident	Initial treatment within 48 hours of the accident	Initial treatment within 72 hours of the accident. Unlimited follow-up care.
Emergency Medical	Initial treatment within 48 hours	Not covered (see Optional Major Medical)	Initial treatment within 72 hours
Radiation Therapy	Covered	Covered	Covered
Chemotherapy	Covered	Not covered (see Optional Major Medical)	Covered
Hydrotherapy/ Physiotherapy	Covered	Not Covered (see Optional Major Medical)	Covered
Diagnostic Services	Covered	Covered. Limited to: x-ray examinations with films, ultrasound when used as a substitute for x-rays with films, metabolism testing, radioactive isotope studies, cardiographic and encephalographic examinations.	Covered

BENEFITS DESCRIPTION	UMWA	USWA	UAW
Hospital Coverage - Basic			
OUTPATIENT			
Pre-Admission Testing	Covered	Covered when performed within 5 days of the scheduled admission	Covered
Surgery	Covered	Covered	Covered
ADDITIONAL BENEFITS			
Skilled Nursing Facility	Covered	Not Covered (see Optional Major Medical)	Up to 730 days or two days for every one day of unused hospital care. 100% payment.
Home Health Care Agency	Covered	Not Covered (see Optional Major Medical)	Each 3 days of care used for home care reduced hospital days by one day.
Kidney Dialysis	Covered	Covered in outpatient department	Covered
PHYSICIANS' SERVICES			
In-Hospital Medical Visits	Covered with copays	120	365/730
Surgical Services	Covered	Covered	Covered
Recurrent/Related Surgeries	Covered	Performed in the home, physician's office or outpatient department of a hospital. Maximum payment of $150/calendar year.	Covered

BENEFITS DESCRIPTION	UMWA	USWA	UAW
PHYSICIANS' SERVICES			
Surgical Assistants	Same as USWA	Covered for a licensed physician who actively assists the operating surgeon provided that the need for an assistant is medically appropriate and the hospital does not employ surgical interns, residents or house staff who are utilized for such assistance.	Same as USWA
Second Surgical Opinion Program	None	None	Voluntary
Non-Compliance Penalty	N/A	N/A	None
PHYSICIANS' SERVICES - BASIC			
Anesthesia	Covered	Covered	Covered
Radiation Therapy/ Chemotherapy	Covered Covered provided that it is not experimental	Covered Not covered (see Optional Major Medical)	Covered Same as UMWA
Diagnostic X-Ray and Ultrasound	Covered	$75 maximum payment per calendar year	Covered
Diagnostic Examinations	Covered with copays	$75 maximum payment per calendar year. Limited to the following services: radioactive isotope studies, metabolism testing, cardiographic and encephalographic examinations.	Covered

BENEFITS DESCRIPTION	UMWA	USWA	UAW
PHYSICIANS' SERVICES - Basic			
Concurrent Care	Same as USWA	Medical/Surgical care covered when medically necessary and rendered by different physicians in different specialties	Same as USWA
Emergency Accident	Within 48 hours after accident	Within 48 hours after the accident; unlimited follow-up care	Within 72 hour after the accident. Unlimited follow-up care
Emergency Medical	Within 48 hours of the onset of the medical emergency	Not covered (see Optional Major Medical)	Same as Emergency Accident
Skilled Nursing Facility	Covered	Not covered (see Optional Major Medical)	2 Visits in a 7-day period
Home Health Care	Covered	Not covered (see Optional Major Medical)	Not covered

BENEFITS DESCRIPTION	UMWA	USWA*	UAW
MAJOR MEDICAL			
Ambulance	Covered (also includes coverage for other transportation)	Covered	Covered under basic plan
Blood	Covered	Blood, blood plasma in excess of 3 pints and transfusions	Not covered
Chemotherapy	Covered	Covered	Covered
Chiropractic Care	Not Covered	Not Covered	Not Covered
Consultations	Covered w/copays	Covered	Covered under basic plan
Diagnostic X-Ray and Lab	Covered	Covered amounts exceeding the diagnostic maximums under Basic Blue Shield	Covered under basic plan
Durable Medical Equipment	Covered	Covered	Covered under basic plan
Emergency Medical	Covered	Covered	Covered under basic plan
Eyeglasses/Contact Lenses	One pair following cataract surgery for the prescription and fitting	One pair following cataract surgery for the prescription and fitting	One pair following cataract surgery for the prescription and fitting
Hearing Aids	Same as USWA (also covers necessary repairs and maintenance)	Covered including the examination for prescription and fitting	Covered separately-includes examination
Home and Office Visits	Covered w/copays	Covered	Covered

* Optional Major Medical program is an optional program and requires retiree contributions.

BENEFITS DESCRIPTION	UMWA	USWA*	UAW
MAJOR MEDICAL			
Home Health Care Agency	Covered under Basic	Covered – 100 visits per calendar year	Covered under Basic
Hydrotherapy/ Physiotherapy	Covered under Basic	Covered	Covered under Basic
Immunizations	Covered	Covered except for travel	Not covered
Mental/Nervous	Covered (see basic section)	$1,500 maximum payment per calendar year. Psychologists services payable only for psychological testing	Not covered
Physical Therapy	Covered	Covered	Covered under basic plan
Prescription Drugs	Covered w/copays	Covered – includes 90% reimbursement for Generics	Participating provider-100% less $5.00 copay
Skilled Nursing Facility	Covered under Basic	Covered	Covered under Basic
Private Room	Covered when medically necessary	Covered when medically necessary	Covered under basic plan
Prosthetics	Covered. Replacements covered when medically necessary	Covered. Replacements covered when medically necessary	Covered under basic plan
Oxygen & Administration	Covered	Covered	Covered

* Optional Major Medical program is an optional program and requires retiree contributions.

BENEFITS DESCRIPTION	UMWA	USWA*	UAW
MAJOR MEDICAL			
R.N.'s	Covered in a SNF or patient's home through Home Health Care Agency	Covered	Covered
L.P.N.	Covered in a SNF or patient's home through Home Health Care Agency	In hospital when required; out of hospital when required. Services in excess of 240 hours paid at 50%	Covered
VISION CARE	Applicable to active and retired employee and their eligible dependents. Fee schedule with frequency limitation every 2 years	Not covered	Applicable active employees, retirees and their eligible dependents. Fee schedule with frequency limitation every 2 years.

Benefit	Actual Charge Up to Maximum Amount
Visual exam	$20
Per lens -	
Single vision	$10
Bifocal	$15
Trifocal	$20
Lenticular	$25
Contact	$15
Frames	$14

Benefit	Actual Charge Up to Maximum Amount
Visual exam	
Ophthalmologist	$40.60
Optometrist	$34.00
Per lens -	
Single vision	$19.50
Bifocal	$26.75
Trifocal	$34.00
Lenticular	$41.30
Contact	$26.75
Frames	$25.60

The chart references the current UAW health care package. In recently concluded rounds of collective bargaining, the health care package has been changed for both GM and Ford workers.

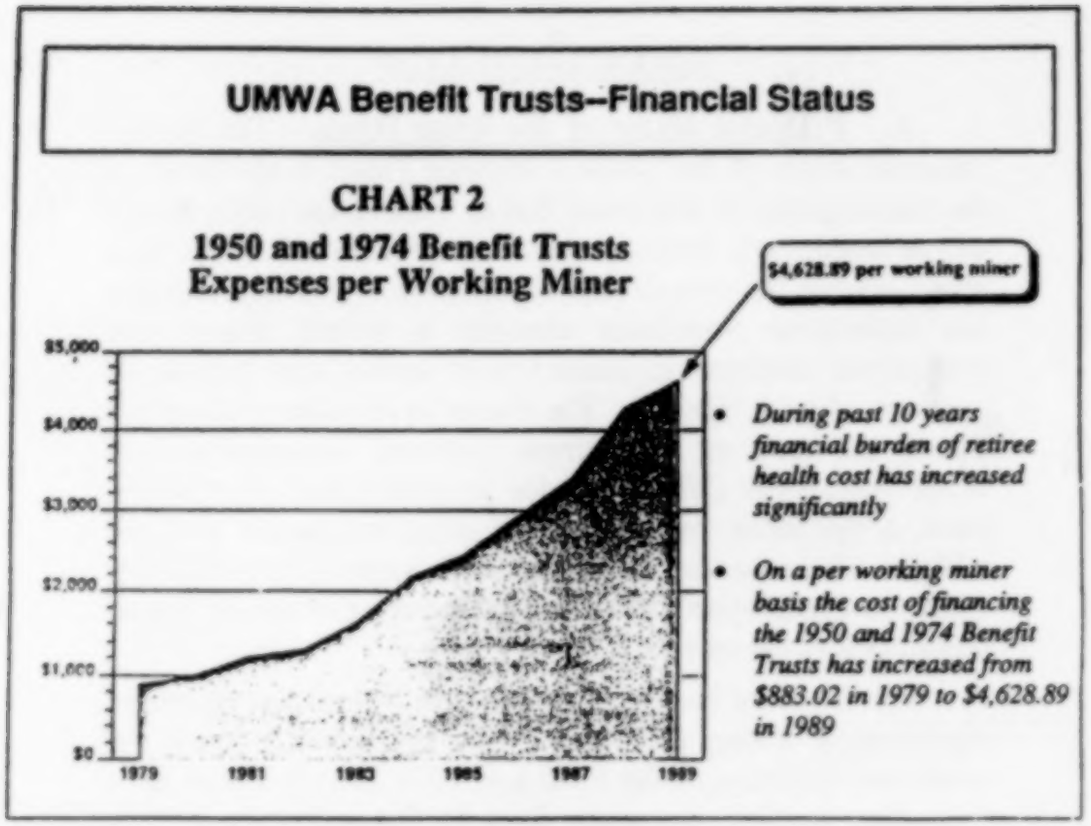
* Optional Major Medical program is an optional program and requires retiree contributions.

CHAPTER FOUR

FINANCIAL STATUS

A. Financial Status of the Trust Funds. The current financial status of the UMWA Benefit Trusts is the result of the convergence of numerous forces both in the coal industry and in health care. Medical care inflation in the U.S. has been about double the overall rate of inflation. The coal industry has undergone significant changes in recent years, with precipitous declines in employment levels and substantial numbers of mine closings. The Funds have suffered shortfalls during the term of the current National Bituminous Coal Wage Agreement (NBCWA) due to insufficient contribution rates, a declining base of contributing companies and the addition of thousands of court-ordered "orphan" beneficiaries whose last employers are no longer operating or are no longer signatories to the current NBCWA.

The financial burden of retiree health costs has increased significantly during the 1980s. Over the past 10 years, the combined expenses of the 1950 and 1974 Benefit Trusts have more than doubled, increasing from $117.4 million in 1979 to $245.3 million in 1989. The annual cost of financing both health care plans, per-working miner, has increased from about $883 to $4,628. (Figure 6)



(FIGURE 6)

At present, each active miner supports 2.4 Funds' beneficiaries, while 10 years ago each miner supported only 1.6 beneficiaries. In addition, active miners support retirees and widows who receive medical care through single employer insurance plans.

The funding base for both Funds currently is declining faster than the beneficiary population. Over the past 20 years, coal production from mines signatory to the NBCWA contracts and contributing to the Funds has declined, while non-NBCWA mines have increased production. NBCWA mines today represent only about 30 percent of total coal industry production and new and tougher environmental regulations expected to go into effect in the near future pursuant to Clean Air Act amendments aimed at controlling acid rain could diminish the funding base even further.

As of July 31, 1990, both Trust Funds showed a $114.7 million deficit, despite the increased contributions from coal operators.[10]

The Funds have brought legal action against a number of employers that are not currently signatory but were signatory to the prior National Bituminous Coal Wage Agreements, seeking to enforce the obligation of those employers to continue to contribute to the Funds. The Funds also have sued the BCOA to increase the rate of contribution to the Trust in order to effectuate the guarantee of benefits contained in the collective bargaining agreement.

1. 1950 Benefit Fund. Total benefit expenses for the Fund in FY 1989 were $202.4 million. As of December 1989, there were 114,300 total beneficiaries: 31 percent retired miners, 41 percent surviving spouses and 28 percent dependents. About half of the beneficiaries worked for employers who are no longer in operation or no longer making contributions to the Fund, reflecting the significant changes that have occurred in the coal industry in recent decades.

The 1950 Fund is essentially a closed Fund limited to retirees as of December 31, 1975, and their dependents. The total number of beneficiaries has declined about six percent over the last several years. This continuing decline reflects the high mortality rate which for the over 65 age group, is 30 percent higher than the national average for males and 16 percent higher for females. It is estimated that the 1950 Fund could conceivably cease operation about the year 2030 upon the death of the last beneficiary.

Despite the decline in the benefit population and implementation of cost containment measures in 1984 and 1988, the cost of providing health care continues to rise, although at a rate below the national average for medical care inflation, and is projected to do so in the future.

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[10] The Funds contend that the BCOA is required to establish further increases in contributions pursuant to the guarantee clause of the NBCWA of 1988.

In FY 1989, the Fund spent $78.9 million for prescription drugs, $71.6 million for physician services and $39.8 million for hospital services.[11] The net health expenses for the Fund in FY 1989 were as follows: 41.5 percent for drugs; 37.6 percent for doctors and 20.9 percent for hospitals. The relatively large share of prescription drug costs reflects the fact that Medicare does not cover prescription drugs and the 1950 Fund bears the entire cost.

During the five-year period from 1984 to 1989, the Fund's prescription drug expenses increased 79 percent and physician services rose 66 percent. The cost of hospital inpatient care declined by 12 percent due to efforts by the Funds to control costs in this area.

The 1950 Benefit Trust is vulnerable to unexpected economic downturns, strikes or congressional action, such as the recent repeal of Catastrophic Care legislation or the Clean Air Act. In addition, the Fund also is involved in litigation that can affect the financial status of the Fund.

Since 1978, with the establishment of employer health plans, the UMWA Funds have functioned essentially as a Medicare wraparound plan with a prescription drug program. The vast majority of Funds' beneficiaries are Medicare enrollees.

Under a special arrangement with Medicare, beneficiaries are provided "one-stop shopping." The Funds perform administrative services for beneficiaries and pay providers for care. In turn, the Funds receive reimbursement from Medicare, both for the costs of health services and for the overhead costs of administration.

The Funds provide services that would otherwise be provided by a Medicare Part B (physicians services) carrier. They do not, however, reimburse hospitals under Medicare Part A.

Retirees covered under coal companies' plans, although eligible for the same benefits as those covered under the

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[11] These amounts exclude death benefits and administrative costs.

Funds, are not provided "one-stop shopping." Company plan retirees who are Medicare eligible are served by their community Part A and Part B Medicare contractors, with company plans providing wraparound coverage of deductibles and coinsurance.

In late 1989, a dispute existed between the Funds and Medicare as to the appropriate level of reimbursement. Cost reports remained unsettled from FY 1985. Negotiators for the Funds and Health Care Financing Administration (HCFA) addressed reimbursement methodology and the need to shift from reimbursement made on the basis of Funds' cash payments to Funds' accrued obligations to providers.

Cost reports through 1984 had been settled consistently on the basis of average prevailing charge limits used by Medicare carriers. Medicare had proposed that rather than applying prevailing charges to determine the Funds' allowable costs, they planned to use the average amount paid by Medicare carriers. The proposed payment screen would by definition be lower.

During the Commission's deliberations, in late September of 1990, the Funds and Medicare resolved the reimbursement dispute in the context of moving toward a capitated reimbursement arrangement for FY 1991 and the future.

Under the capitation arrangement, the Funds are to be paid a predetermined amount per member per month, and the Funds are to provide Medicare services to beneficiaries. If the Funds' actual costs exceed the capitation amount, the signatory employers will be expected to make up the shortfall. If actual costs are less than the capitation amount, the Funds would retain any Medicare payment in excess of actual costs to offset future costs of the Funds. For each year after FY 1991, the payment rate will be increased by a percentage that is based on the Part B national per capita cost, as determined and published annually. A demonstration project is to evaluate whether a capitated payment arrangement will provide a mutually beneficial cost-effective method of

payment for Medicare-covered services for the Funds' beneficiaries.

The negotiated settlement allows for termination 30 days after mutual agreement to end the program, and permits the Funds to terminate unilaterally on 90 days notice. Upon termination, or failure to enter into a demonstration program, the Funds may reinstate the arrangement in effect at the time of the settlement. Under a reinstated arrangement, allowable costs would be determined by comparing the Funds' average payment with a computed average Medicare reasonable charge for a sample of procedures and localities.

Capitation reimbursement offers better incentives for cost savings and simplified reimbursement methodology. Capitation reimbursement has the advantage of providing prompt and predictable reimbursement to the Funds, enabling them to strike better bargains with providers. Capitation allows Medicare the opportunity to predictably control costs for a defined population of beneficiaries. This arrangement constitutes a form of "carve-out" under the Volume Performance Standards recently enacted by the Congress in order to bring Medicare Part B costs under control.

Medicare Part B spending nationwide has been spiraling out of control. The Funds offer a mechanism for helping to control excessive utilization of physicians' services while protecting beneficiaries. Capitated Medicare payments to the Funds have been structured to strengthen that mechanism.

The Funds also will receive substantial cash payments under the settlement's provisions for a change from a cash to accrual accounting in the Funds' cost reports. This cash may be used only to pay the Funds' backlog of Medicare covered claims.

2. 1974 Benefit Fund. Total expenses for the Fund in FY 1989 were $30.7 million. As of December 1989, there were 12,752 total beneficiaries: 42 percent retired miners and 58 percent widows, spouses and other dependents. All of the beneficiaries of the 1974 Fund are "orphans" who have no

employment relationship with current signatories, but whose last employer has terminated their health benefit coverage.

In the past two years, the Fund's population has more than doubled. The rapid growth reflects the severe contraction of coal industry employment in the 1980s and recent court decisions which have added 61% of the beneficiaries to the Fund. The average age of a beneficiary in the 1974 Benefit Fund is 62 years old.

The 1974 Fund's gross per capita health care expenses have increased 52 percent over the past five years. The amount is still below the national average, as a result of the cost containment measures implemented by the Fund.

In FY 1989, the Fund's total expenses were $30.7 million of which $8.1 million was spent for physician services, $5.3 million for prescription drugs and $4.8 million for hospital care. The net expenses for the Fund are divided as follows: 44.7 percent for physicians, 29.1 percent for drugs and 26.2 percent for hospitals.[12]

During the most recent five-year period, prescription drug expenses increased 87 percent and doctor costs rose 55 percent. The cost of inpatient hospital care declined by 17 percent due to aggressive cost containment measures implemented by the Fund.

A number of financial and legal issues have combined to leave the Fund with net assets of only $1.6 million for FY 1989. Projections for mid-1990 show a deficit of $24.8 million. Expenses exceed $3 million per-month with $7.5 million in retroactive payments required by the Nobel case. Other litigation is also in progress that could further impact the solvency of the Fund. The Funds have brought legal action against a number of employers that are not currently signatory but were signatory to the prior National Bituminous Coal Wage Agreements, seeking to enforce the obligation of those employers to continue to contribute to the Funds. The

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[12] These figures do not include the cost of death benefits, administrative costs and court decisions.

Funds also have sued the BCOA to increase the rate of contribution to the Trust in order to effectuate the guarantee of benefits contained in the collective bargaining agreement.

3. 1950 Pension Fund. As of July 1, 1990, the plan remains fully funded, since the market value of assets exceeds the current liability of accrued benefits. The number of participants, including spouses who become eligible upon the death of their husbands, was 108,750. The number of plan participants, excluding spouses, decreased by 4.7 percent last year.

For the year ending June 30, 1990, the plan had net assets of approximately $1.7 billion. Fund expenses totaled $5.8 million and benefit payments were in excess of $224 million. The plan had an actuarial surplus of about $237 million as of July 1, 1990.

A number of suggestions have been offered pertaining to the use of the surplus. One option is to apply a portion of the surplus to eliminate the current deficit in the 1950 Benefit Fund. Transferring the surplus is not currently allowed by law and would need Congressional approval. If the current pool of beneficiaries expires before the funds are spent, the surplus reverts to the 1974 Pension Fund.

4. 1974 Pension Fund. As of July 1, 1989, the total number of reported plan participants was relatively unchanged, increasing slightly over the year from 217,617 to 217,759. The total number of reported active participants declined last year by 14 percent from 64,647 to 55,348.

As of February 1, 1990, monthly benefits were increased for all categories of beneficiaries. The benefit increases increased the actuarial liability by nearly $168 million.

As of July 1, 1990, the actuarial asset value of the Fund was $3.5 billion. Benefits paid totaled more than $224 million. The difference between the actuarial value of accumulated plan benefits and the net assets available for benefits was almost $108 million.

The basic benefit for a 30-year retiree at age 55 is $491 per month. The final benefit at age 62 for a 30-year retiree is $622 per month. (Figure 7) By comparison the basic monthly benefit for a steelworker ranges from approximately $870 to $1,070 and for an auto worker is $1,500 at age 55 dropping to $795 at age 62.

Comparison of Monthly Pension Benefits
30 Year Retiree
1974 PLAN

	UAW	USWA	UAW
Age 55	$491	$870 / $1,080	$795
Basic Temp to Age 62		$200	$705
Age 62	$622	$870 / $1,080	$795

(FIGURE 7)

B. Projected Costs and Revenues. Consulting actuaries Milliman & Robertson developed possible trends and projected costs and revenues for a 20-year period for the Benefit Funds. Experience data provided by the Funds shows that gross health expense per capita has increased 9.1 percent per year for the 1950 Benefit Trust and 8.4 percent per year for the 1974 Benefit Trust over the past five years. But since an increasing portion of the population is eligible for Medicare each year, actual Funds net per-capita costs are increasing more slowly.

Most experts predict that medical care cost will not continue to escalate indefinitely at the rates of the past decade. However, a moderation of health care cost increases will not affect all segments of the community equally.

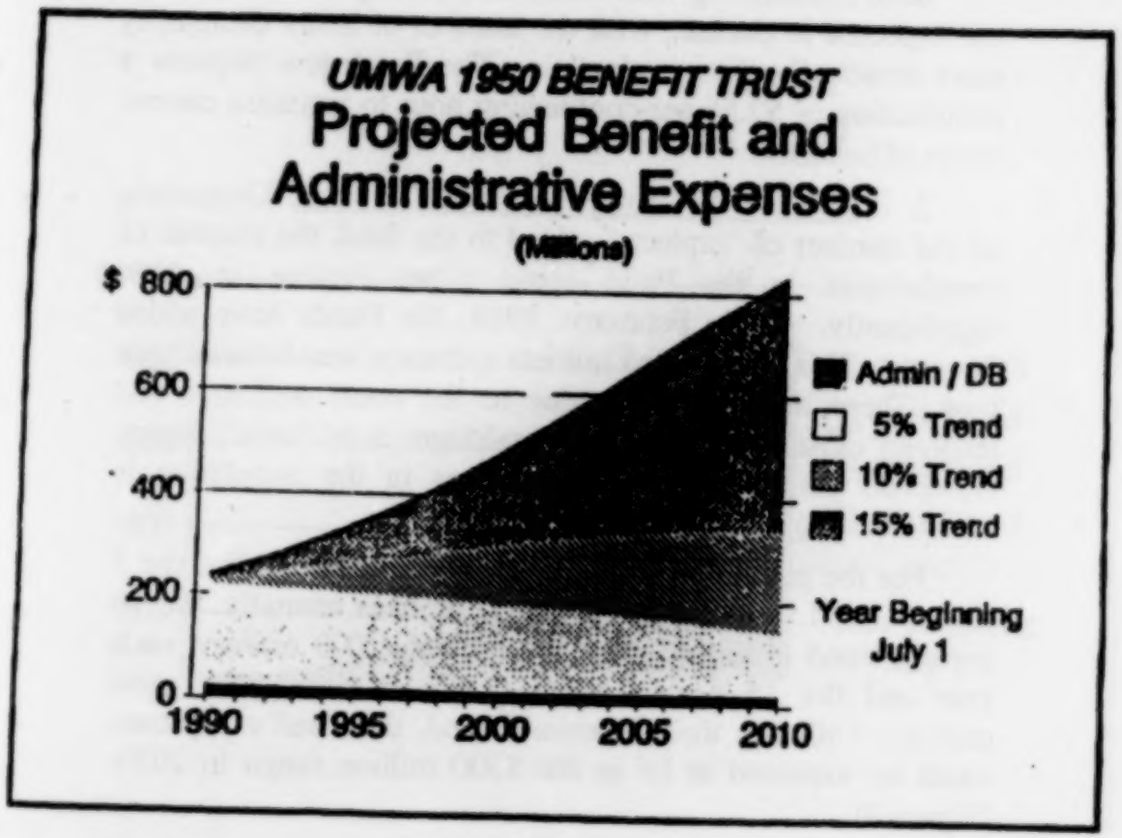
For FY 1990, conforming hours (those worked under the NBCWA) were 88.9 million, signatory hours, including hours worked under conforming and nonconforming agreements, were 91.8 million and the projection is a 3 percent decline per-year. Productivity is currently 3.29 tons per-hour with a 2.5 percent increase projected each year.

The cost projections are based on 3 alternative assumptions regarding trends in costs-per-beneficiary - - 5 percent, 10 percent and 15 percent increases in future years.

About 20 percent of the Funds' current medical costs are for physician services rendered to Medicare beneficiaries. This proportion will grow as more of the Funds' beneficiaries reach age 65. Federal legislation in this area (such as Catastrophic care) could lead to reductions in the overall net per-capita costs for the Funds.

1. 20-Year Projections for 1950 Fund. By the year 2010, the Fund is expected to be predominantly a widow's fund, with less than 3,000 retired miners remaining in the fund. In addition, virtually all beneficiaries will be covered under Medicare. As mentioned earlier, the Fund could expire by the year 2030.

At the end of FY 1990, the current expenses of the Fund are approximately $229 million and are projected to grow, utilizing the 10 percent trend to about $367 million. The 10 percent trend is utilized because in recent years the Fund's expenses have grown at approximately 9 percent a year. (Figure 8)

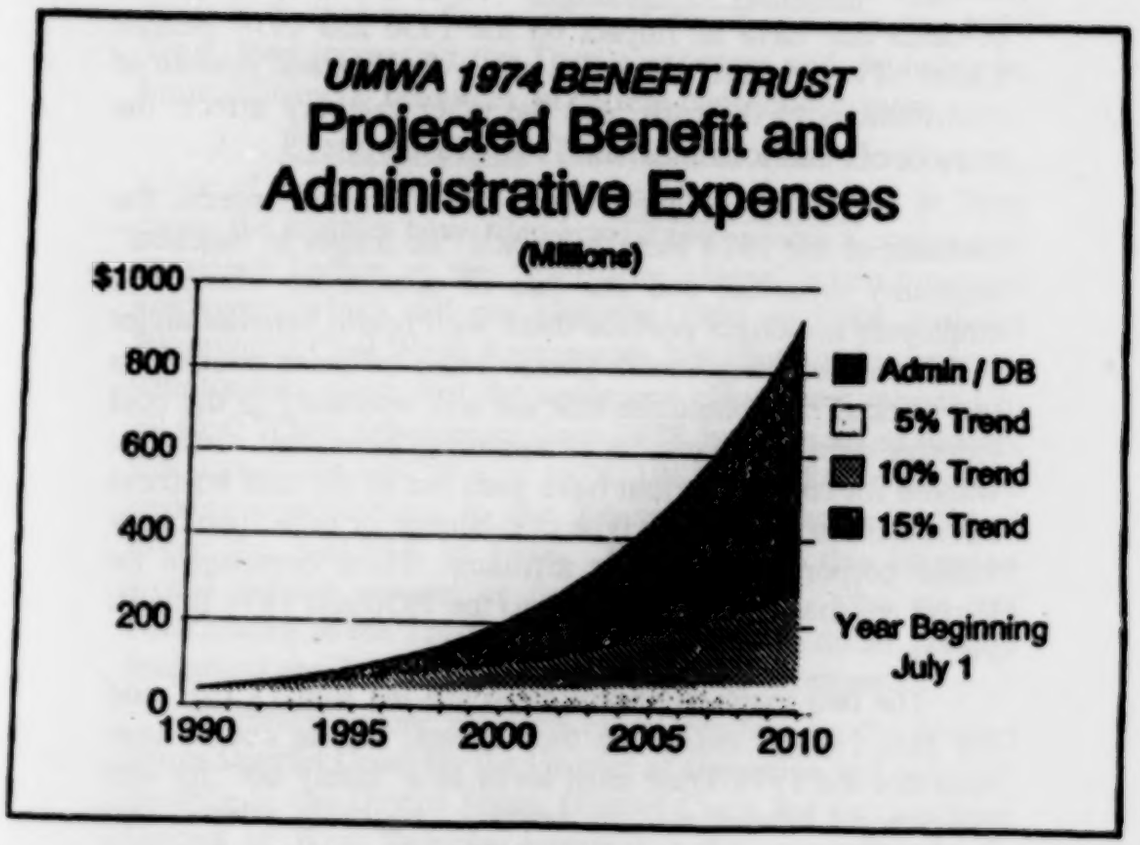


(FIGURE 8)

Both conforming man-hours and tonnage of coal mined are expected to decline, with the number of hours decreasing more drastically than production. The Fund now requires a contribution of $2.55 per-conforming hour to maintain current levels of benefits.

2. 20-Year Projections for the 1974 Fund. Depending on the number of "orphans" added to the fund, the number of beneficiaries in the Fund could either decline or grow significantly. Since February, 1988, the Funds have added more than 1,000 new card holders (primary beneficiaries) per year. These additions were due to the court decisions and resolved most of the pending "no-longer-in-business" issues. However, the rate of future increases in the population is difficult to project.

For the projection of expenses, the actuaries linked the 5 percent trend to the addition of 500 orphans annually, the 10 percent trend is linked to an increase of 1,000 orphans each year and the 15 percent trend is linked with 1,500 extra orphans. Utilizing the 10 percent trend, the Fund's expenses could be expected to be in the $300 million range in 2010. (Figure 9)



(FIGURE 9)

Signatory hours are projected to decline by three percent each year and the Benefit Fund cost per-hour, using the 10 percent trend, is projected to increase substantially to nearly $5 per-hour. On the basis of tonnage mined, the projected cost-per-ton, under the 10 percent trend rises from approximately $.12 per ton to almost $1.

3. 20-Year Projections for the Combined Funds. Currently, the 1950 Benefit Fund is clearly dominant in terms of the number of beneficiaries. But, by the year 2010, assuming continuing additions of orphans as described above, the two Funds will be about equal in population. The main difference is that the 1950 Fund will be predominantly widows. The combined Funds, using the 10 percent growth factor, would have annual expenses topping the $600 million mark.

C. Summary of Litigation. There are three categories of cases that have an impact on the 1950 and 1974 Benefit Trusts . Two of these categories affect the base and amount of contributions to the trust, and the other category affects the number of beneficiaries in the 1974 Trust.

1. Eligibility Cases. This line of cases concerns the meaning of the 1974 Benefit Trust's "no longer in business" eligibility criterion, and the fate of pensioners whose last employers no longer provide them with health benefits under individual company health plans. Some of these pensioners last worked for companies that are still operating in the coal industry on a non-signatory or nonunion basis, and some last worked for companies that have gone out of the coal business but remain in some other type of business, or have financially viable corporate parents or affiliates. These companies no longer are making contributions to the 1950 and 1974 Benefit Funds.

The two main eligibility cases are the Royal Coal[13] and the Max Nobel[14] cases. In these cases, federal courts have held that the 1974 Trust must serve as a "safety net" for any pensioners subsequent to January 1, 1976 whose last employer is no longer signatory to the current National Bituminous Coal Wage Agreement (NBCWA) and whose last employer is not obligated to provide benefits to the pensioner under an individual company health plan. The Nobel case was decided by the United States District Court for the Western District of Pennsylvania in late 1989, and was affirmed without opinion by the Third Circuit Court of Appeals. On September 17, 1990, BCOA filed a petition for certiorari asking the Supreme Court of the United States to review the Nobel case.

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[13] District 29, UMWA v. UMWA 1974 Benefit Plan and Trust, 826 F.2d 280 (4th Cir. 1987), cert. denied, 485 U.S. 935 (1988).

[14] United Mine Workers of America International Union v. Max Nobel, 720 F.Supp. 1169 (W.D. Pa. 1989), aff'd without opinion, 902 F.2d 1558 (3rd Cir. 1990), petition for cert. filed, (Sept. 17, 1990).

The result of these and other closely related eligibility cases is to increase the number of beneficiaries in the 1974 Trust, thus increasing the Trust's expenses and depleting its limited financial resources, at current contribution rates.

2. Evergreen Cases. This line of cases involves the scope of the contribution base to each of the Trusts. In these cases, the trustees have filed lawsuits to enforce a contractual provision known as the "evergreen clause" against several employers which did not sign the 1984 or 1988 National Bituminous Coal Wage Agreements, but continued to operate. The trustees claim that the evergreen clause, incorporated in all Coal Wage Agreements since 1978, requires all employers that signed the NBCWA of 1978, 1981, or 1984, to continue making contributions to the Trusts at the rate established under the NBCWA of 1988. If successful, this litigation would require present or former signatories, who are not contributing to the Trusts at the current rates to do so, thereby increasing the Trusts' contribution base and revenues.

Currently, there are four cases pending in the United States District Court for the District of Columbia and one case pending in the United States District Court for the Southern District of West Virginia, concerning the evergreen clause. The issue in one of the District of Columbia cases is whether former signatories have a current obligation to contribute to the Trusts, even though they are not signatory to the NBCWA of 1988.[15] The other three District of Columbia cases and the West Virginia case concern whether employers that are signatory to the evergreen clause can lawfully negotiate separate agreements with the UMWA that purport to permit those employers to contribute nothing to the Trusts, or to continue at reduced rates or on terms different from the NBCWA.[16]

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[15] United Mine Workers of America 1974 Pension Trust v. A & E Coal Company, (No. 88-1126-TFH).

[16] United Mine Workers of America 1974 Pension Trust v. The Pittston Company, No. 88-0969-TFH; United Mine Workers of America 1950 Benefit Plan and Trust v. Pittsburgh & Midway Coal Mining Co.,

3. Guarantee Cases. There are two cases pending in the District of Columbia that have been brought by the trustees against BCOA to require BCOA to increase the rate at which employers contribute to the Trusts.

One of the cases concerns the contribution rate to the 1950 Benefit Trust,[17] and the other case concerns the contribution rate to the 1974 Benefit Trust.[18] In the "Guarantee Cases" litigation, BCOA acknowledges that it has authority under the so-called guarantee clause of the NBCWA to increase the rate at which employers contribute to the Trusts. BCOA contends, however, that its members and other signatory employers are not obligated to pay a disproportionate share of the Trusts' revenue needs, and that signatory employers should not have to pay for the benefits of financially viable companies who are improperly dumping their retiree health costs into the Trusts. BCOA further contends that if all employers signatory to the evergreen clause were complying with their contractual obligations and making full contributions to the Trusts, and if the trustees were prudently managing the funds, the contribution rates established under the agreement would be sufficient to pay for the benefits of all the Trusts' legitimate beneficiaries.

On June 29, 1990, the U.S. District Court for the District of Columbia issued a preliminary injunction requiring BCOA to increase the contribution rate to the 1974 Benefit Trust so that an additional $2 million per month is paid to the 1974 Benefit Trust on each of September 10, 1990, October 10, 1990, November 10, 1990, and December 10, 1990, unless the BCOA can establish that alternative sources of revenue have

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No. 88-3716-TFH, consolidated with Pierce v. United Mine Workers of America 1950 Benefit Trust, No. 89-2833-TFH; Connors v. Island Creek Corp., No. 87-1210-SSH, consolidated with Connors v. Drummond Coal Co., No. 87-1973-SSH, United Mine Workers of America 1974 Pension Trust v. Rawl Sales & Processing Co., (No. 3:90-0890, S.D.W.Va.).

[17] UMWA 1950 Benefit Plan and Trust v. BCOA, (No. 89-1744-TPJ, D.D.C), appeal docketed, (No. 90-7139, D.C. Cir., Sept. 17, 1990).

[18] UMWA 1974 Benefit Plan and Trust v. BCOA, (No. 90-0674-TPJ, D.D.C).

become available prior to those dates. On August 14, 1990, the court issued a preliminary injunction, later modified on August 16 and September 7, 1990, requiring BCOA to increase the contribution rate to the 1950 Benefit Trust so that an additional $6 million per month will be paid to the 1950 Benefit Trust on each of October 10, 1990, November 10, 1990, December 10, 1990 and January 10, 1991, unless the BCOA can establish that alternative sources of revenue have become available prior to those dates. BCOA has appealed the preliminary injunction in the 1950 Benefit Trust case, and that appeal is pending in the United States Court of Appeals for the District of Columbia Circuit.

CHAPTER FIVE

FINDINGS AND RECOMMENDATIONS

The solution to the health care crisis in the coal industry consists of two parts. The first part deals with liquidating the deficit and assuring the long-term solvency of the Funds. The second part deals with the implementation of cost containment measures to reduce the expense involved in providing health care benefits to retired miners and their families.

In arriving at its findings and recommendations, the Commission considered a number of analytical questions that are critical to resolving the long-term crisis of retiree health care in the coal industry. (See Appendix 1.) Based upon its consideration of these and other questions, the information available, and the time permitted, the Commission arrived at a broad consensus, recognizing that further work will be required and that modifications may occur.

A. CONSENSUS.

First, and most broadly, the members of the Commission believe that the Commission's main objective is to find a long-term solution to the problem of delivering and financing health care in the coal industry. In addition, there is a consensus of the Commission that is, agreement of most of the Commission members, on the following points:

1. Contribution Obligations. Contribution obligations should be statutorily imposed on past signatories, pursuing a test similar to the ERISA "control group" test, possibly reaching back to the signatory class of 1978.

2. Withdrawal Liability. Withdrawal liability should be imposed prospectively to prevent dumping, that is, shifting the liability for health care to employers who have no relationship with the employee.

3. Transfer of Pension Surplus. The surplus in the 1950 Pension Trust should be transferred in one of several

ways to fund the deficits in the 1950 and 1974 Benefit Trusts, as part of an overall financing package.

4. State-of-the-Art Cost Containment and Managed Care. Any plan should use state-of-the-art cost containment and managed care measures as part of an overall package of health care delivery and financing, as described in Section D of this Chapter.

5. Re-enrollment of Beneficiaries. Comprehensive re-enrollment and certification of beneficiaries is appropriate to ensure that benefits are directed only to those entitled to receive them.

6. Long-term Financing. Any residual financing requirement must be limited to the smallest level practical. The contribution obligation that might be imposed on those with no contractual or historic connection to the Funds should be at the lowest practicable level: (1) after those with a contractual or historic connection have contributed; (2) after any pension surplus has been used appropriately, and (3) after managed care and cost containment measures outlined in Section D of this Chapter have been implemented.

7. Flexibility in Determining Dimensions of the Contribution Base. There should be flexibility and further consideration on exactly how any broadened contribution obligation might work. The assessments could be calculated based on hours worked, tons mined, and tons imported. Also, the rate need not be the same for all operators and for all coal. Variations based on BTU content may be appropriate, as well as variation based on past connection with the Funds.

8. "Sunset" Provision on Financing Structure. A "sunset" provision, which would re-evaluate the new delivery system and financing structure, would be appropriate after a period of time.

9. Limited Applicability of Proposed Solutions. These proposed solutions are not permanent solutions for the coal industry; nor are they intended for any other industry.

10. Extension beyond 1993. Any financing package must extend beyond 1993.

In short, the Commission has reached an understanding on a wide range of issues aimed at resolving the crisis of retiree health care in the coal industry. Most important of these are the imposition of a statutory obligation to contribute on current and past signatories, mechanisms to prevent future dumping of retiree health care obligations, authority to utilize excess pension assets and the implementation of state-of-the-art managed care and cost containment techniques.

While a broad consensus exists on these points, the Commission did not develop a consensus on the question of who should provide financing for orphan retirees. Many Commissioners believe that the orphans represent an industry-wide problem that should be resolved on an industry-wide basis. Others believe that only current and past signatories should be required to finance orphan health care. This represents the principal substantive disagreement among Commission members.

B. FUNDING

Because of the lack of consensus on the question of who should pay for orphans, the Commission has reviewed an industry-wide funding proposal and an alternative funding proposal. The Commission believes that both proposals, modified as may be appropriate, should be considered, along with any other funding arrangements that may be developed, to resolve the crisis in retiree health care in the coal industry.

1. Industry-Wide Funding Plan

The crisis of retiree health care in the coal industry derives from three related problems. First, some employers have sought to avoid, or are avoiding, their obligations to provide health care benefits to retirees and their families, foisting the cost of providing promised benefits on other employers. Second, an ever-growing population of orphan retirees is being supported by a shrinking group of employers and employees. And third, the cost of providing health care benefits to retirees has increased significantly. These problems must be resolved to obtain a long-term solution to retiree health care in the coal industry. This proposal will achieve that result.

I.

CONGRESS SHOULD AUTHORIZE THE CREATION OF A NEW ENTITY CALLED THE COAL INDUSTRY RETIREE BENEFIT FUND TO PROVIDE HEALTH CARE TO ORPHAN RETIREES.

This Fund, created by statute, would provide health care benefits to orphan retirees whose last employer (using an ERISA control group definition) is "out of business". This would include orphan beneficiaries currently in the UMWA 1950 and 1974 Benefit Funds and future orphans of employers -- whether signatory or non-signatory to a collective bargaining agreement -- that meet the "out of business" test. The Fund would be vested with rights to prevent dumping of obligations. The beneficiaries would receive the level of retiree health care benefits they were entitled to receive at the time of entry. The Fund would be financed by an industry fee which applies to all employers in the coal business, including a fee on imported coal.

II.

A NEW UMWA 1991 BENEFIT FUND SHOULD BE CREATED TO PROVIDE BENEFITS TO RETIREES OF CURRENT AND PAST SIGNATORIES OF THE NBCWA THAT REMAIN IN BUSINESS.

This Fund would provide health care benefits to retirees whose last employer (using an ERISA control group definition) remains in business. This would include beneficiaries of the 1950 and 1974 Benefit Funds whose last employer is signatory to the current NBCWA or was signatory to the NBCWA of 1978, 1981, or 1984. Congress would impose a statutory obligation on such employers to finance the cost of health care for its retirees who are placed in the 1991 Fund. Each employer will be required to pay a fair share into the Fund to provide benefits to its beneficiaries. Beneficiaries of the 1991 Fund will receive the same health care benefits they receive in the 1950 or 1974 Funds. To

create greater purchasing power and economies of scale, employers may opt to provide benefits for active employees and individual company retirees under the 1974 Pension Plan through the 1991 Benefit Fund, upon proper payment to the Fund.

III.

CONGRESS SHOULD AUTHORIZE THE SETTLORS TO UTILIZE THE EXCESS ASSETS OF THE UMWA 1950 PENSION PLAN TO REDUCE EXISTING DEFICITS IN THE BENEFIT PLANS.

Historically, the UMWA Pension and Benefit Trusts have been considered a single entity for a number of purposes, including payments. There has been a "reallocation" option in the agreement since 1974 giving BCOA the right to divert contributions from the pension plan to the benefit plan when necessary. BCOA has, over the years, either on its own or at the request of the UMWA, exercised this option many times, most recently immediately prior to the expiration of the 1984 NBCWA.

The 1950 Pension Trust is over funded by approximately $237 million. The obligations are covered by a dedicated bond portfolio which virtually guarantees the payment of benefits even in the event that there is no further signatory employment. Congress should authorize the settlors to utilize the excess pension assets to reduce the existing deficits in the 1950 and 1974 Benefit Funds.

IV.

CONGRESS SHOULD PROHIBIT THE DUMPING OF RETIREE HEALTH CARE OBLIGATIONS SO LONG AS THE EMPLOYER REMAINS IN BUSINESS AND HAS ASSETS TO PAY FOR SUCH OBLIGATIONS.

The ability of an employer to renege on commitments to its retirees and dump liability on the Funds disrupts any effective long range solution. Dumping liability is fatal to any multi-

employer fund as it creates a clear incentive for employers to withdraw as quickly as possible. This disruptive potential is recognized clearly in the 1980 Multi-employer Pension Plan Amendments Act, and action under that statute has served to stabilize most pension funds including the two established under the NBCWA.

Unfortunately, there is no comparable anti-dumping structure in the health care area. The parties imposed substantial withdrawal liability on current signatories to the 1988 Agreement. However, thousands of beneficiaries whose last employers are non-signatory are a substantial burden on the Fund. More than half of current beneficiaries of the 1974 Trust are former employees or widows of companies still in the coal business or in other business ventures. The Commission believes that this situation is intolerable and must be stopped.

V.

CONGRESS SHOULD IMPOSE A STATUTORY OBLIGATION TO CONTRIBUTE ON SIGNATORIES TO THE NATIONAL BITUMINOUS COAL WAGE AGREEMENT OF 1978 AND ANY SUCCESSOR AGREEMENT.

Throughout our deliberations, the responsibility of past signatories was a major concern. This subject has been a part of the collective bargaining dilemma that led to the founding of the Commission, is the topic of current litigation and provides an incentive for employers to leave the multi-employer plan.

This, when combined with the anti-dumping recommendation, is aimed at the stabilization of the contribution base and the prevention of a "last man's" club. The "evergreen" obligation has been a part of the agreement between the parties since 1978 and was designed to prevent massive withdrawals from the Funds. Because long and counterproductive delays can be expected in attempts to enforce this obligation through litigation, Congress should

codify the continuing obligation to contribute clause to which current and former signatories agreed.

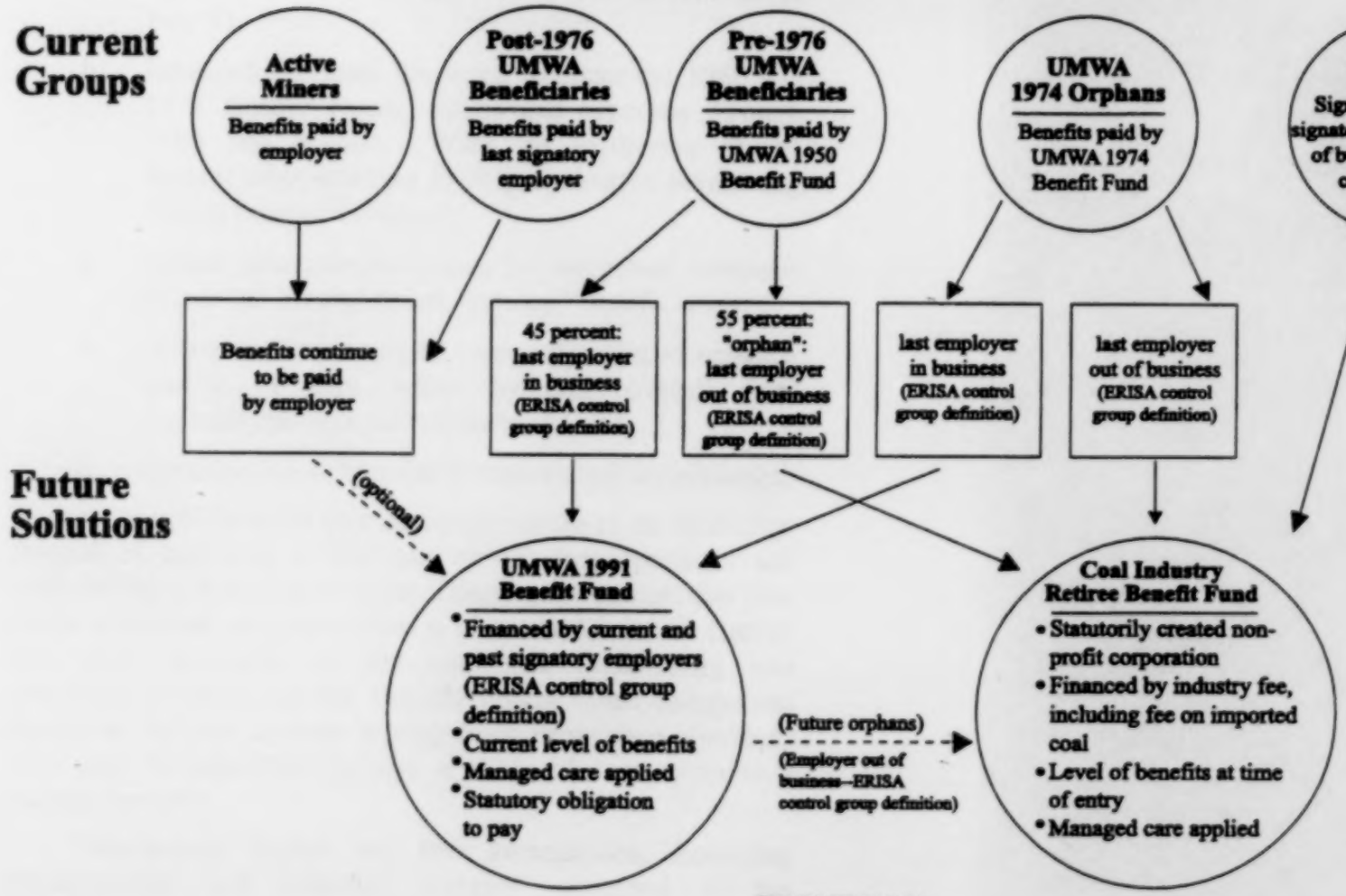
VI.

STATE-OF-THE-ART MANAGED CARE AND COST CONTAINMENT TECHNIQUES SHOULD BE IMPLEMENTED AS PART OF AN OVERALL SOLUTION TO THE RETIREE HEALTH CARE CRISIS.

The Commission discussed ways to improve the quality of health care and, at the same time, reduce the cost of health care. Proper use of managed care and cost containment can achieve these objectives without the loss or reduction of benefits. Such techniques should be implemented in both of the newly created funds. (Figure 10)

INDUSTRY-WIDE FUNDING PLAN

Coal Industry Retiree Health Benefits



(FIGURE 10)

2. ALTERNATIVE FUNDING PLAN

An alternative approach to the financing problem exists. It seeks objectives very similar to those of the industry-wide proposal. This approach has a different funding mechanism than the industry-wide proposal for making retiree health care for coal miners financially secure.

Specifically, any plan should meet the following needs:

a. Eliminate the current deficit of $83 million as of July 31, 1990;

b. Establish adequate financing to cover the 1950 and 1974 Benefit Funds claims and expenses through 1995 and beyond. With the expiration of the present labor contract in1993, collective bargaining should become involved;

c. Ensure adequate provisions for additional revenues to provide for any future "orphan" beneficiaries;

d. Utilize current managed care techniques to enhance quality of care while reducing overall fund expenditures on a per capita basis; and,

e. Continue health benefits to retirees and beneficiaries.

The major difference in this approach relates to its financing. Instead of imposing a new tax on all coal operators and establishing a new agency of the federal government, this plan seeks additional revenues from a broadened base of current and past signatories to the contracts, establishing and providing revenues for the Benefit Funds. Past obligations would be defined as those arising from firms once signatory who may be identified through a chain of succession to a current operator.

Summarized below are the assumptions, financing arrangements and potential margins contained in the alternative financing proposal.

1. Assumptions

- Actual experience under the 1950 and 1974 Benefit Funds will be consistent with 10% trend projections, which includes assumption of 1,000 new orphans, annually, under the 1974 Fund. (See Margins below.)
- Actual experience under the 1950 and 1974 Pension Funds will be consistent with current actuarial assumptions.
- Managed care recommendations will be adopted as of January 1, 1991.
- Medicare screens for physicians will be adopted as of January 1, 1991.
- Current beneficiaries will be subject to re-enrollment during 1991.
- Legislation will be enacted prohibiting future "dumping" and providing for pension-type withdrawal liability provisions.
- Legislation will be enacted permitting transfer of surplus assets from the 1950 Pension Fund to the 1950 and 1974 Benefit Funds.
- Legislation will be enacted requiring past signatories to contribute to Benefit Funds on an equitable basis.

2. Existing Deficit. The deficit under the 1950 and 1974 Benefit Funds as of July 31, 1990 is about $83 million, after adjusting for the recent court injunctions and the Medicare capitation agreement. The projected deficit as of January 1, 1991 is about $115 million. This will be eliminated by a transfer of $115 million from the 1950 Pension Fund.

3. Financing For Calendar Years 1991 and 1992

a. The current hourly contribution rate of $2.17 for the 1950 Fund will be indexed by the Consumer Price Index (CPI) from April 1, 1989 to January 1, 1991 and to January 1, 1992, respectively.

The 8-cent hourly contribution rate for the 1974 Fund will be increased to 10-cents effective January 1, 1991 and 12-cents effective January 1, 1992.

b. Based on the above financing, the Funds will be short about $70 million each year. This will be provided for as follows:

- A "reachback" to former signatories - this would result in revenues of about $30 million per year.(Revenues are somewhat uncertain as former signatories could object, claiming they bargained out of the agreement in good faith.)
- An estimated $10 million reduction in benefit payments from the adoption of Medicare screens for physicians.
- The balance is provided for by a per tonnage charge on signatory coal of 10 to 12-cents or the balance is provided for by an annual transfer of $30 million from the 1950 Pension Fund.

4. Financing For Calendar Years 1992 through 1995

a. The 1992 hourly contribution rates would be further indexed, by CPI, to each January 1 of 1993, 1994 and 1995.

b. The estimated shortfall for each of these calendar years is about $100 million. This will be provided for as follows:

- The "reachback" will continue to provide about $30 million.
- The savings from Medicare screens will continue at about $10 million.

- The remainder of the pension surplus (about $160 million as of January 1, 1993) will provide about $55 million per year.*
- The balance of the required $100 million will come from a per tonnage charge on signatory coal of about 2-cents.*

5. Possible Margins

- No financial recognition of potential savings from the adoption of managed care provisions. These could result in savings of $10 million per year increasing with inflation.
- If there are no new "orphans" to the 1974 Fund (rather than 1,000 assumed in original projections) then there will be additional surplus of $8 million on January 1, 1993 and $45 million on January 1, 1996.
- If the court-ordered "orphans" were returned to their former employers then there could be additional surplus of up to $90 million on January 1, 1996.
- Actual savings from adoption of Medicare screens could be 5% to 6% rather than assumed 4%. Also $10 million will gradually increase with inflation up to about $12 to $15 million on January 1, 1996.

6. Net Effects

If actual experience is consistent with that assumed, including the indexing of employer contributions and the adoption of managed care

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* If $30 million pension surplus is used in years 1991 and 1992, then only $30 million a year will be available for years 1993 through 1995. Hence, per tonnage charge would be about 10 cents rather than 2-cents.

provisions, then the total additional surplus on January 1, 1996 could amount to $125-$175 million.

7. Other Possible Changes

- Increase benefits for 1950 retirees by 3% on January 1, 1993. This will cost about $40 to $45 million and could be provided for from indicated margins.
- Increase the $5 co-payments for physicians' services and prescription drugs to $5.25 on January 1, 1991 and by 5% thereafter, with appropriate adjustments to annual maximums.

C. COST CONTAINMENT MEASURES.

The Coal Commission believes that cost containment represents a promising approach for reducing the overall cost of providing health care to UMWA retirees and their dependents.

The approach described preserves freedom of choice while reinforcing managed care network use by allowing a point of service decision as to whether a network medical provider will be used. The Funds, with the backing of the UMWA and the contributing employers, have provided the groundwork for additional managed care approaches. It is expected that the cost containment measures described would not substantially add to the administrative costs.

1. The major elements of this approach are:

   a. Select physicians on the basis of demonstrated quality care and medical cost efficiency, using state-of-the-art methodology.

   b. Implement formulary for drugs and subject the prescription program to a rigorous review of appropriate use.

   c. Obtain a unit price discount of 10% to 20% in exchange for patient volume and preferred

provider status with the amount of the potential discount varying by geographic region.

d. Limit benefit payments to physicians to the Medicare allowable charge, while protecting beneficiaries from balance billing by providers.

e. Utilize Medicare's "appropriateness of service" protocols in the claims payment function where they are more stringent.

f. Create mandatory utilization review (UR) procedures, but place the responsibility to follow such procedures on the physician/hospital, not the beneficiaries.

g. Expect savings from a combination of selecting the most efficient physicians and state-of-the-art utilization management techniques, including ambulatory care techniques, to range from 5% to 15% for medical services delivered by the managed care network. The amount of actual savings will vary by the effectiveness of utilization management.

h. To receive maximum benefits available, beneficiaries must access specialty medical care only through referral by the primary care physician pre-selected by the beneficiaries.

i. Beneficiaries have the option to use a managed care network physician or hospital at the time medical services are needed (point-of-service). The consequence of not using a network provider is a reduced benefit plan, perhaps a Comprehensive Major Medical Plan with deductibles and coinsurance with a modest annual maximum out of pocket expense or the hold harmless protection might be waived outside the network.

j. The rationale for reduced medical benefits for non-network providers is to offset the less efficient medical delivery system.

2. Comments. In those areas where there is no competition for patients among medical providers, the primary strategy for improving the cost effectiveness of the medical benefit program must primarily be mandatory UR procedures using the latest techniques available. Medical services not properly submitted to UR procedures might be subject to a penalty or no payment if a retrospective review indicates the services are not medically necessary.

Without a provider pre-agreement to accept Fund determinations of proper cost and utilization for medical services received, the "hold harmless" protection of beneficiaries from balance billing of excessive fees by medical providers will continue to be needed. Mandatory UR procedures (rather than the current voluntary UR program) reflecting state of the art techniques may be expected to reduce costs by 2% to 5% in these noncompetitive areas, which is lower than the savings possible from a managed medical delivery system.

In those areas where there is an aggregation of beneficiaries in a noncompetitive medical market, the Fund may have a meaningful impact on the medical providers. If there is no aggregation of beneficiaries, then the influence of the Fund on medical providers will be minimal, but so will the financial impact on the total Fund medical expense from the small number of beneficiaries in that area.

3. Variations on the Managed Care Option. It might also be helpful to develop a risk sharing arrangement with network providers in as many areas as possible, perhaps forming physician hospital organizations and sharing some percentage of risk for capitated risk pools.

4. Medicare Capitation Arrangement. The current administration is interested in promoting managed care applications to the Medicare population, and has negotiated a capitation arrangement between HCFA and the Funds.

It should be noted that an ideal arrangement would include both Part A and Part B benefits in some fashion which would allow the Fund to benefit from the savings potential

from reduced inappropriate use of inpatient hospital services. It is also important to remember that reduced inpatient hospital use is often partially offset by increased use of Part B Medicare benefits.

The capitation agreement with HCFA will make it even more important for the Fund to move aggressively forward with the effective use of state-of-the-art managed care techniques.

5. Long-Term Impact of Managed Care Option. The cost savings obtained through reducing benefits through deductible and coinsurance provisions result in a one-time nonrecurring savings. Once the savings achieved from reduced benefits (including any utilization reduction due to cost sharing) have been realized, the future increases in medical benefit costs will be essentially the same as the Medical Component of the Consumer Price Index (CPI).

Long-term savings from a managed medical delivery system can occur in connection with two factors:

a. Annual negotiated unit price prospective payment arrangements with providers which are linked to an appropriate external reference such as the All Items-CPI, rather than the Medical Component, or an index or reference appropriate to the coal industry, provided that overall aggregate payments are within prospectively determined limits.

b. Efficient medical care resulting in less intensity of medical services per patient served. It is expected that efficient medical care received from a managed medical delivery system will result in better quality medicine, fewer medical services per patient and better coordination of those services.

This lower utilization rate can be expected to result in a lower medical cost trend over subsequent years. It is expected that an unmanaged medical delivery system will likely require three to six years of incremental progress to achieve medical efficiency.

6. Long-Term Cost Containment. Long-term cost containment can be achieved in three ways:

a. Develop protocols of practice by the medical profession that are sensitive to resource constraints, sometimes called "standards," "guidelines," or "parameters." These are efforts by respected medical authorities to specify what are appropriate and inappropriate treatment patterns, which can specify a preferred mode of treatment or set boundaries on the range of appropriate practice. At the very least, these protocols should be developed and disseminated to physicians providing care under the Plans.

b. Apply the guidelines as a part of utilization review, with due regard to the need to maintain reasonable clinical autonomy and efficient physician decision-making.

c. Articulate expenditure targets, similar to the Medicare Volume Performance Standards, noncompliance with which could trigger further action through negotiation or by the plan administrator.

CHAPTER SIX

STATEMENTS OF COMMISSIONERS

A. Statement of Vice Chairman Henry H. Perritt. I believe that the two concepts offered at the meeting of October 17, 1990 are extremely close in their major features, and that it would have been desirable to bridge the gap and have a single recommendation. I believe that the industry-wide proposal is the better of the two.

I do not attribute the views expressed in this statement to any other member of the Commission. They are my own, and are offered to fulfill my obligation as a member of the Commission to offer my best independent judgment about the best way to solve the problem given to us, rather than offering an approach that has been tailored to conform to external constraints imposed by others' perceptions of Administration policy.

The financing crisis for retiree health care results from the concentration of funding responsibilities for a generic industry problem on a shrinking fraction of the industry. Any voluntary contractual mechanism to make such funding obligations legally enforceable is doomed to failure because the remaining contributors—have stronger and stronger incentives not to contribute voluntarily. For this reason alone, the usual collective bargaining approach under the general labor laws is not a feasible financing approach. Whatever the appropriate financing obligations are, they must be imposed by external law and made enforceable without regard to contract duration. Thus, the only question is who should be subject to the mandatory premiums.

The Administration and the Commission quite properly prefer private sector arrangements for financing and delivering health care. The coal industry is distinctive for being a sector in which a comprehensive private structure has existed for forty years to finance and deliver health care benefits. This structure has been determined by the United States Courts of Appeals in two judicial circuits to guarantee lifetime health care benefits to persons already retired. An

essential principle of private contract law is that legally operative expectations based on contracts be fulfilled. Otherwise private arrangements through contract cannot operate. That means that the commitments to the retirees must be honored.

The judicial branch of the government, however, through other judicial decisions and through delay in the litigation process, has undermined the key features of the present private arrangements. These judicial decisions allow employers to dump their retiree health benefit obligations on the existing health care funds, and to evade contribution obligations. The judicial decisions taken together say that the health benefits must be paid, while depriving the private sector of the means to pay for them. The equities here are not those of present signatories and the UMWA seeking to ensnare someone else in their private arrangements; the equitable realities are that the law has frustrated realization of a private arrangement to provide a safety net for people who have a vested right to retiree health care benefits.

A variety of other governmental policies reflected in labor law and interpretation of labor law have made it difficult for the United Mine Workers of America to maintain a sufficient organization base and contractual uniformity to secure an adequate financing base. Apart from the equities, the reality is that an historically comprehensive, innovative, and strong private arrangement for health care is falling apart. When the present system falls apart there will be instability, not only in the organized part of the industry but in the coal industry generally.

If health care delivery and financing cannot be reformed, the following scenario is conceivable. There would be a cataclysmic breakup in multi-employer bargaining in 1992, accompanied by significant economic disruption. The large individual producers that dominate BCOA would withdraw, and would take the position that the evergreen and guarantee litigation frees them, upon contract expiration, from the obligation to pay for the Funds' deficits. Regardless of the legal merits of this position, litigating the merits would take

years. The Funds, deprived of adequate contributions, would suspend, terminate, or cut back benefits to retirees, producing strike activity that might be difficult or impossible for the UMWA to control. History suggests that the strike activity would spread broadly throughout the coal industry.

In the end, someone is going to pay for retiree health care, and the amount required does not change with different definitions of the contributor population. There are only three possibilities: the retirees themselves, the taxpayer, the coal industry. The retirees cannot do it; they lack the resources. The present financing structure is falling apart, and the likelihood is that it will not exist after 1993. Seeking to continue the status quo thus ultimately throws the burden of financing health care that was promised to beneficiaries on the taxpayer. It is not good public policy deliberately to embark on a course that will make the public sector responsible for providing health care for a significant new group of retirees who historically have had a comprehensive structure for financing and delivering health care. This is not the time to dismantle private structures and enlarge the role of the public sector. An industry-wide industry financing mechanism is the only way to avoid that outcome. The Industry-Wide Funding Plan appropriately allocates financing responsibility among three groups: signatories, past signatories and the rest of the industry.

Stabilizing financing of the retiree health care system serves a number of interests. It serves the interests of proponents of private solutions. It serves the interests of those who believe in the integrity of private contracts. It serves the interests of anyone who believes that retirees who worked hard to create economic prosperity for others should not suffer from breaches of faith in delivering health benefits they were promised in their declining years.

The insistence on solving this problem entirely through collective bargaining is unrealistic and disingenuous. There is an assumption buried in the proposals for solving this problem through bargaining, which I find unacceptable. The assumption accepts as an outcome the cancellation by individual employers

of health care benefits promised to retirees (or cancellation of financing arrangements for those benefits). The Supreme Court of the United States has recognized that retirees have little bargaining power on their own. The National Labor Relations Act has been interpreted to prevent unions from representing the interests of these disempowered citizens. I cannot agree to allowing the makers of promises to walk away from their promises when these retirees are the victims. Any approach that does not provide for financing of the health care plan beyond 1993 encourages this outcome.

I do not believe that it is appropriate statutorily to require present signatories to continue to pay for benefits for someone else's retirees. Such a perpetual obligation is not imposed by the labor laws, and I am not persuaded that they agreed to pay, by themselves.

The question then becomes whether financing should be extended only to those with an historic connection with the Funds or whether it should be extended industry-wide. It is appropriate to impose some residual mandatory premiums industry-wide for two reasons: First, the mandatory premiums finance orphans, who by definition are not associated with any employer still in business; the orphan responsibility is a broad industry responsibility. Second, the boundary between past signatories and the rest of the industry is so indistinct as to be an inappropriate conceptual limitation on the financing structure.

The testimony at the Commission meeting on October 10, 1990 reveals that there is no clear line between those with an historic connection and those without such a connection.

Many of those companies who professed not to have any connection with the retiree health care financing problem have in fact mined coal with miners covered by the Funds and the collectively bargained contribution obligations and thus could be said to have "dumped" retirees, although technical definitions of "successorship" labor law may not formally obligate the surviving and testifying entities. This points up the difficulty of any solution that depends only on financing by those with a "responsibility." The very people who

proclaim lack of responsibility most vigorously have at least some de facto responsibility.

Notably, significant non-BCOA support exists for an industry-wide financing approach.

There is no such thing as mining coal and yet having no involvement in the crisis confronting health care financing and delivery in the coal industry. Contract operations are a strong phenomenon in coal mining, as are thinly capitalized subsidiaries It is not uncommon for a contract operator or a thinly capitalized subsidiary or joint venture to walk away from obligations to finance retiree health care. Frequently entities who now appear not to have had any historic involvement with the Funds were in fact involved as contributors of capital, as participants in joint ventures or as purchasers of contract coal. It is difficult to know whose hands are clean.

It is not only a matter of clean hands. It is also a matter of administrative feasibility. It is extremely difficult to build a financing mechanism that relies entirely on unscrambling the supply contracts, joint ventures, capital structures, and investment roles of a decade ago to pin responsibility on investment capital that has walked away from freely undertaken funding obligations.

Even more generally, the coal operator who sells coal at a price not reflecting contributions for retiree health care contributes to the problem by eroding the market share of the operators who must recover the costs of retiree health care not only for their own retirees but also for orphans. An industry-wide financing approach tends to level the competitive playing field, because it spreads the cost of health care more broadly.

Several variations on industry-wide financing are worth further consideration. First, and most obvious, are variations in the assessment rate structure. Assessments could be calculated based on hours, or they could be calculated based on tons mined. An hours-based formula tends to increase the burden on low-productivity operations and decrease it on

higher productivity operations. Because productivity tends to increase over time, an hours-based formula tends to erode the contribution based in the long run. Also, related to the rate structure is the fact that the rate need not be the same for all operators and for all coal. Some variation base on BTU content may be appropriate, and some variation based on past connection with the collectively bargained funds may also be appropriate.

Second, it is possible to "annuitize" the exposure for true orphans and finance this amount with a discrete number of assessments. For example, one might conclude that the present value of the cost of health care through the Coal Industry Retiree Benefit Fund from now until the year 2039 is X. An assessment of Y cents per ton for three years would raise X, thus, covering the requirement. Under this variation, no long term industry assessment would be involved.

Third, an industry-wide assessment for the Coal Industry Retiree Benefit Fund could be put in place by modifying the Abandoned Mines Land assessment as proposed in testimony by Arch Minerals Corporation, presented in the Commission's public hearing on October 10, 1990.

An essential element in the Industry-Wide Funding Plan is establishing a private, nonprofit corporation, with a strong and specific legislative mandate to use state-of-the-art managed care and cost containment techniques, as defined in Section D of Chapter Five of this Report. A statutory mandate, specifying the types of managed care procedures to be implemented, is necessary to ensure that the new entity actually uses the managed care techniques and that unanticipated legal impediments to their use do not impede cost containment efforts.

The new entities are appropriate ways to achieve cost containment. While the existing funds have made considerable progress in managing costs, historical controversies and the diffusion of governance responsibility make it difficult for state of the art cost containment to be implemented fully through the existing structure. The new entities also are necessary to improve health care delivery

more generally in the long run. Ambitious health care reform cannot be accomplished on a fragmented single employer basis; a strong central administrative mechanism is necessary to implement managed care and cost containment. Perpetuating the present structural arrangement and delivery patterns would make it more difficult to conform care delivery practices to new health care financing and delivery concepts or to integrate them with new statutory initiatives developed separate from the Coal Commission or coal industry collective bargaining.

The Industry-Wide Funding Plan makes maximum use of private institutions and economic incentives rather than compulsion. It is the only approach that produces a real prospect of managed care and cost containment, because single employer plans are not likely, as a practical matter, to have sufficient market power, expertise, or emphasis.

The separate Coal Industry Retiree Benefit Fund also is appropriate because secure, broadly-based financing for the orphans cannot be arranged through a collectively bargained structure. A significant part of the industry is not organized by the UMWA. Any structural arrangement that forces this part of the industry to make contributions or premium payments to a collectively bargained delivery mechanism is infeasible. A new entity established by law and made appropriately accountable to public institutions is necessary to avoid these problems.

There is no reason to suppose that creating a new entity, such as the Coal Industry Retiree Benefit Fund proposed creates a new government entitlement program. The Coal Industry Retiree Benefit Fund is a private corporation, and its obligations are not those of the government. Political pressures to increase benefits or to change the financing mechanism would be no different in kind or character from political pressures against any energy tax or in favor of amending the copyright laws -- to identify two subjects in recent experience.

There are significant considerations relating to the presidential value of the Commission's recommendations and

the political reactions thereto. The managed care part of the solution could serve as a precedent for other industries. In contrast, the financing mechanism need not represent a precedent for other industry. The coal industry can be distinguished from other industries with respect to the genesis of the immediate problem, the consequences of failure to solve it, and the government' historic intervention.

The Industry-Wide Funding Plan does not represent the ultimate solution to health care financing and delivery in the coal industry, that will take much debate and more time. The proposal does represent a sound structure within which longer term comprehensive reform can occur.

B. Statement of Commissioner Richard M. Holsten. It is with deep regret that I voice this dissent to the Industry-Wide Funding Plan (the UMWA/BCOA proposal) aimed at resolving the financial deficiencies currently being experienced by the two UMWA health funds. There are at least three areas in that proposal that I cannot in good conscience support.

1. I have no objection to the creation of a new health fund, although I would strongly recommend it be limited to present orphans only so as to avoid an open-ended perpetuation of today's problems. It is the proposed method of financing that bothers me.

The vast majority of coal producers on whom this new tax would fall are not now members of either the BCOA or the UMWA. Most of them have never been part of either group and thus have had no role in the creation, implementation or administration of the Funds. To require these companies now to bail out their direct competitors' health care responsibilities in addition to funding their own employee health care programs would be grossly inequitable and would amount to a subsidy of signatory operators that is no more justified than would be the use of federal tax revenues which the Commission unanimously opposes.

2. The proposal would also broaden the financing base for present UMWA retirees by requiring all former UMWA

employers back to 1978 to contribute to the 1950 Fund on a per capita basis (the "reachback provision").

First, I acknowledge the guarantee of lifetime health benefits that has been contractually made to UMWA pensioners and their dependents. This guarantee has to be honored. Yet there are many companies who, for very valid strategic or economic reasons and using entirely legitimate means, have withdrawn from the Union and, at least according to the courts today, from their obligations to the Funds.

I agree with that part of the Industry-Wide Funding Plan that would tighten up withdrawal provisions in the future. However, to retroactively apply those same restrictions to companies who have legally withdrawn in the past would not only be highly unfair but would upset the very delicate market balance between union and non-union production that exists today within our intensely competitive industry.

Furthermore, this portion of the proposal would establish a dual standard for contract compliance. On the one hand, signatory operators would be required to honor their commitments to fund retiree health care costs. The union, on the other hand, would be relieved of any contractual concessions it may have willingly made to certain coal operators in the form of lower contribution rates to these same funds. If one party to a contract is obligated to honor its commitments, so must the other. The retroactive "reachback" provision would negate that mutuality of commitment and would make a sham of the collective bargaining process.

3. The proposal does very little to correct the underlying deficiencies that have led to the financial crisis currently faced by the Funds, namely, the extremely high cost of health care benefits that are being underwritten by signatory operators.

Apart from some general cost containment features, which may or may not translate into hard dollars, and a proposed tightening of the withdrawal provisions, there is little in the way of cost reduction, cost sharing, eligibility review or

other efforts to lower the cost of providing health care benefits. Thus, the Industry-Wide Funding Plan is pretty much business as usual for signatory operators but spread the pain to others.

The basic cause of the Funds' problems today has really nothing to do with the federal government as some would profess. That argument is a smoke screen. Nor is this a "generic industry problem" as characterized by some. This is simply a UMWA problem and a BCOA problem that, while serious in itself, is restricted to a relatively small and shrinking sector of the U.S. coal industry. It has nothing to do with nonunion companies which today comprise a growing majority of the industry. It is the cumulative result of the collective bargaining process over the years, as far back as 1950, in which the BCOA has progressively made improved health care commitments to the UMWA, commitments that may have been entirely rational at the time but have now become economically unbearable.

The long term solution lies also in the collective bargaining process, not in government intervention and certainly not in a tax on noninvolved parties. The BCOA and the UMWA in their next negotiations in 1993 will have the opportunity to correct the mistakes of the past by revising their new National Bituminous Coal Wage Agreement to better reflect the economic realities of today's market environment.

In the interim, between now and 1993, a bridging can be achieved through the use of surplus pension assets, through cost containment and through reasonable cost reductions. The interim costs to signatory companies, as shown by the Commission's own actuarial projections, would be modest and future costs would be manageable.

Simply put, this is not an industry-wide problem. It does not require an industry-wide solution. This is a BCOA/UMWA problem created by the collective bargaining process and correctable through that same process. In the interim, the present deficits can be eliminated and a smooth and relatively painless transition can be made involving present signatory companies only.

C. Statement of Commissioners Michael J. Mahoney, Carl J. Schramm, Arlene Holen, Richard M. Holsten

I.

HEALTH CARE FUNDING SHOULD PRESERVE THE INTEGRITY OF THE COLLECTIVE BARGAINING PROCESS

Limiting obligations to signatories rests on several considerations. Primemost is that the Benefit Funds are a creature of collective bargaining. Thus, to establish a federally established power to compel non-signatories to contribute to a creature not of their making is fundamentally inequitable and unsound public policy. Since the passage of the Wagner Act, collective bargaining has been, as a matter of public policy, the avenue of resolution for industrial conflict in the United States. This process rests on the ability of the parties to measure each other's bargaining strength and reach a joint resolution of their differences. To erect non-contract streams of revenue to the Funds is to impose the outcome of bargaining on outside parties. To achieve such an outcome would require the subversion of the process of collective bargaining in the coal industry. It would establish artificial subsidies to the implicit price of benefits to the signatories, making the costs of settlement fall on parties altogether removed from the process itself. It would weaken the integrity of the collective bargaining process by providing incentives for promised benefits that cannot be delivered. It would further weaken incentives to monitor contract compliance.

II.

HEALTH CARE FUNDING SHOULD NOT CREATE MARKET INEFFICIENCIES

There is a larger question of social policy relating to industrial efficiency. To establish artificially lower-than-market prices to the signatory parties for the costs of health benefits is to invite inefficient behavior from signatory firms. Such a system clearly establishes a tax whose marginal incidence

would fall on non-signatory operators. Any such system of taxation, neither demonstrably progressive nor fair, establishes what economists call welfare losses. Such losses reflect lost wealth to the economy or society as a result of incentives that implicitly reduce system-wide efficiency. In this case, the firms receiving the transfer will operate at sub-optimal levels, a micro-economic appearance of the phenomenon of moral risk. As the testimony repeatedly suggested, still further incentives to non-signatory operators to avoid the tax would arise.

III.

INEQUITABLE TO IMPOSE BURDEN ON NON-RESPONSIBLE OPERATORS

Issues of elemental fairness are involved. The record shows that reprehensible practices as regards successorship exist in this industry. Thinly capitalized operators, often the sham invention of larger firms, come and go in a fashion that appears to exist only to avoid the risk of being held as a party to the collectively bargained agreement regarding pension and welfare benefits. Nevertheless, while such behavior cannot be condoned, respectable operators who made decisions in the past to move to different locales, invest in different technology, or pursue their business with or without respect to union presence must be recognized. To reach to such firms ex post facto for funding of the bargained benefits, which in many cases will not relate to their own employees either past or present, is nothing but fiscal expedience that cannot be justified.

IV.

SOUND TAX POLICY ARGUES AGAINST SUBSIDIZING THE FUNDS

The notion of taxation of any industry in a fashion different from any other must be viewed with the most vigorous skepticism. In the case of the mining industry, what would evolve under the new tax proposed might be viewed as a system of state-sponsored health care for those who are tied to one

industry. There is no "special case" justification for such a result. While mining has been benefited by government intervention in the past, and has also suffered at the hands of a judiciary inclined to make convenient if not economically-justified decisions to place certain workers under the protection of the Funds, such a history does not compel a conclusion that federal tax policy should operate to subsidize the Funds in the future. To find otherwise would result in a federally supervised tax-based system of health care finance which could be used as precedent in other industries in the future.

V.

NEITHER BLACK LUNG OR ABANDONED MINES PROGRAM SERVES AS PRECEDENT

Much has been made of the precedential value of both the black lung program that reaches all workers and operators in the industry, as well as the program for land reclamation that imposes costs on all firms in the industry. These programs are separable from the question of an industry-wide tax on operators to fund health benefits. In the case of black lung, the program was established as an entitlement whose funding was guaranteed by government. Funding has been provided by the coal industry and general revenues. But apart from the commitment of general revenues to such benefits, the pneumoconiosis program is similar to that of mine reclamation in that both black lung and surface despoliation are common in varying degrees to all coal mining operations. Contractually established benefits, on the other hand, fall only on the parties who contract, and within this universe, the benefits vary widely depending on the circumstances governing the outcome between the union and a specific operator. Witness the existence of non-union firms and non-conforming contracts as evidence. Because of the indivisibility of labor inputs, established as a part of our national labor policy, neither the Black Lung or Abandoned Mines Land Fund serve as precedent to consider in this case.

VI.

ANY NEW TAX SHOULD DEFRAY BLACK-LUNG DEFICIT

The coal industry has been subsidized by forgiveness of interest on the indebtedness of the Black Lung Disability Trust Fund, the deficit of which already exceeds $3 billion. This deficit would have been about $1 billion higher, had not interest accruals been stopped by Congress for five years, between 1986 and 1990. Thus, the Black Lung Disability Trust Fund, which was set up to pay benefits which are the responsibility of the coal industry, has been heavily subsidized by US. taxpayers. Any new industry-wide tax should properly be used first to defray outstanding black lung obligations.

VII.

INEQUITABLE TO FORCE COSTS ON THOSE WITH LESSER BENEFITS

The imposition of an industry-wide tax to support retiree health benefits would create another serious distortion and inequity. Coal users would pass on the implicit costs to their customers. To advance such a position, given that the benefits provided under the contract are fairly described as significantly better than the scope of benefits enjoyed by a majority of working men and women in the United States, would be to force the cost of this substantially above average benefit package on many men and women with no health insurance benefits at all or benefits of lesser quality. Such an outcome is unacceptable given the existence of uninsured individuals in the nation.

VIII.

NEW ENTITY WOULD CREATE FEDERAL LIABILITIES

Establishing a new federal entity, the Coal Industry Retiree Benefit Fund, which would be financed by an industry-wide tax as in the UMWA/BCOA proposal, essentially creates a

federal corporation to broadly guarantee health benefits for both union and non-union operations in the coal industry. Such a federal guarantee of privately-determined health benefits is unprecedented and likely to create enormous future liabilities for the federal government.

CHAPTER SEVEN

CONCLUSION

No fewer than four advisory councils have been charged with the task of studying the problem of health care in America. This suggests that the rising cost of health care may be one of the greatest challenge facing our nation today. It most certainly is the greatest challenge facing the coal industry.

The Commission believes that this Report will be a valuable resource for policy makers because it does not simply analyze the issues involved, and then offer recommendations, but instead contains workable solutions to the complex and troubling problem of providing retiree health care for coal miners.

While the difficulty of providing health care for retired coal miners is symptomatic of the overall health care crisis, the recommendations contained within the Report are specifically tailored to the coal industry. These recommendations, however, are based upon general principles which can be utilized by any industry or provider of health care.

In this era of increasingly difficult fiscal constraints, responsible differences of opinion exist with respect to how to provide long-term financing for the UMWA Health and Retirement Funds. While acknowledging this fact, the Commission is unanimous in expressing a deep sense of urgency that steps be taken to address this problem right now.

APPENDICES

Appendix 1	Controlling Questions
Appendix 2	Principles
Appendix 3	Contribution Rates
Appendix 4	List of Acronyms

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APPENDIX 1

QUESTIONS RAISED DURING COMMISSION DELIBERATIONS

a. Should financing be accomplished through current signatories only?

b. Should financing be accomplished through a group including present signatories and former signatories as of, e.g., 1978 or 1988?

c. Should financing be accomplished through a group, including present signatories, past signatories, and all others in the industry?

d. Can financing be accomplished by contract or is legislation required?

e. Is a new organizational entity required should the present fund, as is or as modified, continue?

f. Should the beneficiary class be frozen or "capped" to include only those presently retired or those as of some date in the future?

g. How should "beneficiary" be defined? Should re-enrollment occur? How should dependents be covered? Should active miners and retirees who are participants in single employer plans be eligible to participate in the multi-employer plan?

h. Assuming that it is necessary to define control group or "affiliate" to implement past signatory contribution obligations or to prohibit dumping, how should those concepts be defined to cover joint venture partnerships, corporate subsidiaries, and parties to supply contracts?

i. How should bankruptcy affect contribution obligations?

j. Under what circumstances can contributing employers terminate the obligation to contribute? What kind of withdrawal liability should exist?

k. What changes, if any, should be made to the preliminary report on cost containment issued on October, 11, 1990?

1. What use, if any, should be made of the pension surplus? Transfer all of the assets to the health care plan? Transfer some of the assets to beneficiaries to fund new co-payments? Use some or all of it for a general pension increase?

m. What should the formula be for contributions? Should contributions be based on tonnage or hours? What should the rate structure be?

n. What forms of contribution might be considered other than traditional contributions by employers?

o. What additional data is required?

APPENDIX 2

PRINCIPLES

In discussing the problem and proposed solutions, sharp differences of opinion were expressed and numerous ideas were exchanged. To assist the Commission in finding a long term solution to the problem of the deficits facing the UMWA Health and Retirement Funds, 14 general principles concerning delivery, funding and general considerations were discussed and generally agreed upon by the Commission.

The 14 principles are as follows:

DELIVERY

1. The health care delivery system should be designed to honor the expectations of coal miners, based on commitments made under the terms of the various National Bituminous Coal Wage Agreements.

2. The health care delivery system should be financially sustainable and the risks covered should be insurable; it should not motivate contributors to seek relief from the program.

3. Any redesigned health care delivery system should reflect current practices that ensure quality and cost effective health care services, including appropriate managed care, plan design, effectiveness of care provided, and cost containment practices.

4. Persons and institutions with a commitment to provide health care should not dump that responsibility on other employers or on public agencies.

5. Because of the nature of the beneficiaries, a multi-employer funding and administration arrangement is necessary to cover retirees under the 1950 and 1974 Benefit Trusts and those who will become eligible for benefits under those Trusts.

6. There should be a central funding and administration arrangement to cover retirees and active employees of operators who wish to provide coverage through such a central arrangement.

7. There must be a clearly defined program, possibly based on regulation and/or competition, to ensure that the program is properly administered and its assets well spent. This is particularly true in the case of mandatory contributions.

8. An effort should be made to define a mechanism to provide a suitable arrangement to cover active and retired miners with health care insurance consistent with insurance principles and proper safeguards with respect to cost and nature of care. A wide range of options should be considered, including reconfiguration of benefits to develop private markets for long term retiree health care insurance, and ensuring the availability of health insurance at reasonable cost to small coal industry employers.

FUNDING

9. The contribution base must be extended on an equitable basis beyond current contributors. The "last person out" phenomenon should be prevented.

10. A governmental role will be necessary to ensure contributions by those with an obligation to contribute.

11. A near term funding source must be found for meeting requirements associated with the larger orphans burden and the smaller contribution base for 1950 Benefit Fund beneficiaries.

12. All other appropriate sources of funding should be explored, consistent with the foregoing principles, to lessen the burden on active employers of providing health care benefits.

GENERAL

13. The role of the federal government should be minimized, and the role of private institutions, including collective bargaining, should be emphasized and strengthened.

14. No approach represents a solution unless it has genuine support from labor and management.

APPENDIX 3

CONTRIBUTION RATES
UMWA HEALTH AND RETIREMENT FUNDS

	Rate per Ton	Rate per Hour
June 1, 1946	$0.05	
July 1, 1947	$0.10	
July 1, 1948	$0.20	
March 6, 1950	$0.30	
October 1, 1952	$0.40	
1971 Agreement		
November 12, 1971	$0.60	
November 12, 1972	$0.65	
May 12, 1973	$0.70	
November 12, 1973	$0.75	
May 12, 1974	$0.80	
1974 Agreement		
December 6, 1974	$0.74	$0.90
December 6, 1975	$0.78	$1.40
December 6, 1976	$0.82	$1.54
1978 Agreement		
March 27, 1978	$1.39	$0.92
April 27, 1978	$1.39	$0.77
March 27, 1979	$1.39	$0.78
March 27, 1980	$1.39	$0.77
1981 Agreement		
June 7, 1991	$1.43	$1.04
June 7, 1982	$1.59	$1.00
June 7, 1983	$1.60	$1.02
1984 Agreement		
October 1, 1984	$1.79	$1.03
October 1, 1985	$1.79	$0.97
October 1, 1986	$1.82	$0.97
October 1, 1987	$1.82	$1.02
1988 Agreement		
February 1, 1988		$2.38
July 1, 1988		$2.55
February 1, 1989		$2.68
May 1, 1989		$2.85
February 1, 1990		$2.96
August 1,1990[19]		$3.21
September1, 1990[20]		$3.96

[19] Four month $0.25 rate increase pursuant to court injunction.

[20] Four month $0.75 rate increase pursuant to court injunction.

APPENDIX 4

LIST OF ACRONYMS

BCOA	-	Bituminous Coal Operations' Association
BTU	-	British Thermal Unit
CPI	-	Consumer Price Index
DOL	-	U.S. Department of Labor
ERISA	-	Employee Retirement Income Security Act
FACA	-	Federal Advisory Committee Act
FDA	-	Food and Drug Administration
FOIA	-	Freedom of Information Act
GSA	-	General Services Administration
HCFA	-	Health Care Financing Administration
HHS	-	U.S. Department of Health and Human Services
HIAA	-	Health Insurance Association of America
HMO	-	Health Maintenance Organization
JCAH	-	Joint Commission for Accreditation of Hospitals and Organizations
NBCWA	-	National Bituminous Coal Wage Agreement
PPO	-	Preferred Provider Organization
TPA	-	Third Party Administrator
UAW	-	United Auto Workers
UMW	-	United Mine Workers
UMWA	-	United Mine Workers of America
UR	-	Utilization Review
USWA	-	United Steel Workers of America